No. 97-1008

In The

Supreme Court of the United States

October Term, 1998

CAROLYN C. CLEVELAND,

Petitioner,

vs.

POLICY MANAGEMENT SYSTEMS CORP; GENERAL INFORMATION SERVICES, a Division of Policy Management Systems Corporation; and CYBERTEK CORP.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

JOINT APPENDIX

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LAW OFFICES OF
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Petition for Certiorari Filed December 15, 1997
Certiorari Granted October 5, 1998

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RELEVANT DOCKET ENTRIES

M-TOL APPEAL
CLOSED JURY

U.S. District Court
Northern District of Texas (Dallas)

CIVIL DOCKET FOR CASE #: 95-CV-2140
N.O. #96-11247

Cleveland v. Policy Mgt Sys Corp, et al.
Assigned to: Magistrate Judge John B Tolle
Demand: $0,000
Lead Docket: None
Dkt# in other court: None

Filed: 09/22/95
Jury demand: Plaintiff
Nature of Suit: 442
Jurisdiction: Federal Question

Cause: 29:0794 Job Discrimination (Handicap)

CAROLYN C CLEVELAND plaintiff	John E Wall, Jr, Attorney at Law 214/887-0173 FAX [COR LD NTC ret] Law Office of John E Wall Jr 5728 Prospect Avenue Suite 2001 Dallas, TX 75206 USA 214/887-0100
v.	
POLICY MANAGEMENT SYSTEMS CORP defendant	David N Kitner, Attorney at Law 214/651-4330 FAX [Cor LD NTC ret] Kimberly Sumner Moore, Attorney at Law

[COR ret]
Strasburger & Price
NationsBank Plaza
901 Main St Ste 4300
PO Box 50100
Dallas, TX 75250-0100
USA
214/651-4618

GENERAL INFORMATION SERVICES
a Division of Policy Management Systems Corporation
defendant

David N Kitner,
Attorney at Law
(See above)
[COR LD NTC ret]
Kimberly Sumner Moore,
Attorney at Law
(See above) [COR ret]

CYBERTEK CORP
defendant

David N Kittner,
Attorney at Law
(See above)
[COR LD NTC ret]
Kimberly Sumner Moore,
Attorney at LAw
(See above) [COR ret]

9/22/95 1 COMPLAINT filed. [Filing Fee $ 120.00 Receipt # 74892 (4) (jrb)] [Entry date 09/25/95]

* * *

10/20/95 6 ANSWER to Complaint by defendant Policy Mgt Sys Corp, [defendant General Info Serv, defendant Cybertek Corp (Attorney David N Kitner, Kimberly Sumner Moore), (4) (svc)] [Entry date 10/23/95]

* * *

6/7/96 17 MOTION with memorandum in support by defendant Policy Mgt Sys Corp, defendant General Info Serv, defendant Cybertek Corp for partial summary judgment (15+) (cjb) [Entry date 06/10/96]

* * *

7/8/96 19 RESPONSE by Carolyn C Cleveland to [17-1] motion for partial summary judgment. (15+) (USC) (bjj) [Entry date 07/09/96]

7/19/96 20 MOTION by defendant Policy Mgt Sys Corp, defendant General Info Serv, defendant Cybertek Corp to amend [6-1] answer (8) (lmn) [Entry date 07/22/96]

7/23/96 21 Objections/RESPONSE by defendant Policy Mgt Sys Corp, defendant General Info Serv, defendant Cybertek Corp in opposition to pltf's evidence filed to [19-1] motion response (6) (krs) [Entry date 07/24/96]

7/23/96 21 MOTION by defendant Policy Mgt Sys Corp, defendant General Info Serv, defendant Cybertek Corp to strike [19-1] motion response (6) (krs) [Entry date 07/24/96]

7/23/96 22 REPLY by defendant Policy Mgt Sys Corp, defendant General Info Serv, defendant Cybertek Corp to response to [17-1] motion for partial summary judgment (15+) USC (krs) [Entry date 07/24/96]

7/23/96 22 MOTION with memorandum in support by defendant Policy Mgt Sys Corp, defendant General Info Serv, defendant Cybertek Corp to supplement summary judgment evidence (15+) USC (krs) [Entry date 07/24/96]

8/2/96 23 RESPONSE by plaintiff Carolyn C Cleveland to [21-1] motion to strike [19-1] motion response/summary judgment evidence (3) (ldm) [Entry date 08/05/96]

8/2/96 23 Agreed MOTION by plaintiff Carolyn C Cleveland for leave to amend [19-1] motion response (3) (ldm) [Entry date 08/05/96]

8/12/96 24 AMENDED RESPONSE by plaintiff Carolyn C Cleveland to [17-1] motion for partial summary judgment (15+) (gjs)

* * *

9/6/96 32 JUDGMENT for defendant Policy Mgt Sys Corp, defendant General Info Serv, defendant Cybertek Corp against plaintiff Carolyn C Cleveland; action dismissed on the merits and defts recover of pltf their costs of action (signed by JBT) Copies to counsel: 09.10.96 Page(s): (wcc) [Entry date 09/10/96]

* * *

10/2/96 35 NOTICE OF APPEAL by plaintiff Carolyn C Cleveland from the final ordered [sic] entered on 9/6/96. Fee payment amount: 105.00 Receipt #85514 Cpy to Judge TO to Cnsl (gjs) [Entry date 10/03/96]

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CAROLYN C. CLEVELAND	)	**CIVIL ACTION NO.**
V.	)	**395CV2140-H**
	)	
POLICY MANAGEMENT	)	
SYSTEMS CORPORATION,	)	
GENERAL INFORMATION	)	
SERVICES, A DIVISION OF	)	
POLICY MANAGEMENT	)	
SYSTEMS CORPORATION	)	
and CYBERTEK	)	
CORPORATION	)	

PLAINTIFF'S ORIGINAL COMPLAINT

(Filed Sep. 22, 1995)

TO THE HONORABLE JUDGE OF SAID COURT:

COMES NOW, Carolyn C. Cleveland, Plaintiff, complaining of Defendants, Policy Management Systems Corporation, General Information Services, A division of Policy Management Systems Corporation and Cybertek Corporation and would respectfully show unto the Court as follows:

1. The jurisdiction of this Court is invoked to seek a redress of violations of the Americans with Disabilities Act of 1991 and TEX. LAB. CODE. ANN. § 451.001 (Vernon Supp. 1995).

2. Plaintiff, Carolyn C. Cleveland, is a female citizen of the United States and a resident of Richardson, Dallas County, Texas. Plaintiff has been employed by Defendant at its facility in Dallas County, Texas. Plaintiff has been

subjected to unlawful employment practices committed in the State of Texas.

3. Defendant Policy Management Systems Corporation is an employer within the meaning of the 29 U.S.C. section 621 et seq. Said Defendant is a South Carolina corporation that may be served by serving its agent for service, C.T. Corporation System, 350 N. St. Paul Street, Dallas, Texas 75201.

4. Defendant General Information Services, A Division of Policy Management Systems Corporation, is an employer within the meaning of the 29 U.S.C. Section 621 et seq. Said Defendant is a South Carolina corporation that may be served by serving its agent for service, C.T. Corporation System, 350 N. St. Paul Street, Dallas, Texas 75201.

5. Defendant Cybertek Corporation is an employer within the meaning of the 29 U.S.C. Section 621 et seq. Said Defendant is a Texas corporation that may be served by serving its agent for service, C.T. Corporation System, 811 Dallas Avenue, Houston, Texas 77002.

6. This is a proceeding for a declaratory judgment, injunctive and other relief to secure the rights of Plaintiff under the Americans with Disabilities Act of 1991 and TEX. LAB. CODE. ANN § 451.001 (Vernon Supp. 1995). It is brought to prevent Defendants from maintaining a policy, practice, custom or usage, of discriminating against Plaintiff in regard to compensation, terms, conditions and privileges of employment.

7. Plaintiff says Defendants discriminated against her on account of her documented disability and for

having instituted a workers' compensation proceeding in the following and other respects:

a. By terminating her;

b. By discriminating against her in the terms, conditions and privileges of her employment;

c. By failing to accommodate her disability.

8. Within the Appropriate time of the acts of which she complains, Plaintiff filed charges of discrimination and disability with the Equal Opportunity Commission. Thereafter, Plaintiff received from said Commission(s) her notices of right-to-sue with respect to her charges of discrimination and disability, and she timely filed suit. All conditions precedent to the filing of this action have been fulfilled.

9. Plaintiff would also show that she was discharged on or about July 15, 1994.

10. Plaintiff has no plan or adequate remedy at law to correct the wrongs complained of herein, and this suit for declaratory and injunctive relief is her only means of securing relief. Further, Plaintiff is now suffering and will continue to suffer irreparable injury from Defendant's policies, practices, customs, and usages set forth herein.

WHEREFORE, Plaintiff respectfully prays that this Court:

a. Grant Plaintiff a permanent injunction, enjoining Defendant, its agents, employees, successors, assigns and all persons in active concert or participation with it, from discriminating against her;

b. Grant Plaintiff a declaratory judgment, declaring Defendant's practices complained of herein to be in violation of Law;

c. Grant Plaintiff backpay, frontpay, damages, exemplary damages or any other appropriate relief to compensate her for the wrongs complained of herein;

d. Grant attorney's fees appropriately recoverable and costs of Court;

e. Grant such other and further relief, including pre-judgment and post-judgment interest, at law or in equity, as the Court deems necessary and proper.

Respectfully submitted,

/s/ **John E. Wall, Jr.**
State Bar No. 20756750
3109 Carlisle, Ste. 103
Dallas, Texas 75204
214-871/8808
214/969-7629 (facsimile)

ATTORNEY FOR PLAINTIFF

REQUEST FOR JURY TRIAL

Plaintiff hereby requests trial by jury.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CAROLYN C. CLEVELAND	§	
	§	
V.	§	
	§	
POLICY MANAGEMENT	§	CIVIL ACTION NO.
SYSTEMS CORPORATION,	§	395CV2140-H
GENERAL INFORMATION	§	
SERVICES, A DIVISION	§	
OF POLICY	§	
MANAGEMENT SYSTEMS	§	
CORPORATION and	§	
CYBERTEK CORPORATION	§	

DEFENDANTS' ORIGINAL ANSWER

COME NOW Policy Management Systems Corporation, General Information Services, and Cybertek Corporation, Defendants in the above styled and numbered cause, and in response to Plaintiff's original Complaint, file the following Original Answer:

1. Defendants admit that this Court has jurisdiction of this matter. Except as otherwise specifically admitted herein, Defendants deny the remaining allegations of paragraph 1 of Plaintiff's Original Complaint.

2. Defendants admit that, upon information and belief, Plaintiff is a resident of Dallas County. Defendants further admit that Plaintiff was an employee of Policy Management Systems Corporation. Defendants further admit that General Information Services is a division of Policy Management Systems Corporation, but is not a separate legal entity. Defendants specifically deny that

Plaintiff was ever an employee of Cybertek Corporation. Defendants further specifically deny that Plaintiff was subjected to unlawful employment practices. Except as otherwise specifically admitted herein, Defendants deny the remaining allegations of Paragraph 2 of Plaintiff's Original Complaint.

3. Defendant Policy Management Systems Corporation makes no response to Paragraph 3 of Plaintiff's Original Complaint because same is jurisdictional and requires no specific response of this Defendant.

4. Defendant General Information Services denies that it was Plaintiff's employer or that it is a South Carolina corporation. Defendant General Information Services makes no response to the remaining allegations of Paragraph 4 of Plaintiff's Original Complaint because same are jurisdictional and require no specific response to this Defendant.

5. Defendant Cybertek Corporation denies that it was Plaintiff's employer. Defendant Cybertek Corporation makes no response to the remaining allegations of Paragraph 5 of Plaintiff's Original Complaint because same are jurisdictional and require no specific response of this Defendant.

6. Defendants deny the allegations of Paragraph 6 of Plaintiff's Original Complaint.

7. Defendants deny the allegations of Paragraph 7 of Plaintiff's Original Complaint.

8. Defendants admit that Plaintiff filed a claim with the Equal Employment Opportunity Commission. Except as otherwise specifically admitted herein, Defendants

deny the remaining allegations of Paragraph 7 of Plaintiff's Original Complaint.

9. Defendants admit that Plaintiff was discharged from her employment with Policy Management Systems Corporation on or about July 15, 1994.

10. Defendants deny the allegations of Paragraph 10 of Plaintiff's Original Complaint.

AFFIRMATIVE DEFENSES

1. Plaintiff's Original Complaint fails to state a claim upon which relief may be granted as to Defendant Cybertek Corporation because it has not and never has been Plaintiff's employer.

2. Plaintiff's Original Complaint fails to state a claim upon which relief may be granted as to Defendant General Information Services because it has not and never has been Plaintiff's employer.

WHEREFORE, PREMISES CONSIDERED, Defendants Policy Management Systems Corporation, General Information Services, and Cybertek Corporation respectfully pray that upon final hearing hereof, judgment be rendered that Plaintiff take nothing by her suit and that

these Defendants go hence without day and recover their costs in this behalf expended.

Respectfully submitted,

/s/ David N. Kitner
DAVID N. KITNER
State Bar No. 11541500
KIMBERLY S. MOORE
State Bar. No. 00784629
901 Main Street, Suite 4330
Dallas, Texas 75202
(214) 651-4300
FAX – (214) 651-4330

ATTORNEYS FOR DEFENDANTS POLICY MANAGEMENT SYSTEMS CORPORATION, GENERAL INFORMATION SERVICES, A DIVISION OF POLICY MANAGEMENT SYSTEMS CORPORATION, AND CYBERTEK CORPORATION

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing instrument has been served upon all counsel of record in accordance with the Federal Rules of Civil Procedure on the 19 day of October, 1995.

/s/ David N. Kitner
DAVID N. KITNER

DISABILITY REPORT

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

PRIVACY ACT/PAPERWORK REDUCTION ACT NOTICE: • • •

A. NAME OF CLAIMANT *Carolyn Ann Cleveland*[1]

B. SOCIAL SECURITY NUMBER *530/26/0461*

C. TELEPHONE NUMBER where you can be reached (include area code) ~~*817*~~ *214-238-9150*

D. WHAT IS YOUR DISABLING CONDITION? (Briefly explain the injury or illness that stops you from working.) *Stroke – which effected [sic] speech & comprehension*

PART I – INFORMATION ABOUT YOUR CONDITION

1. When did your condition first bother you: MONTH *Jan* DAY *7* YEAR *94*

2A. Did you work after the date shown in item 1? (If "no" go on to items 3A and 3B.) [ ] YES [✓] NO

• • •

3A. When did your condition finally make you stop working?

MONTH *JAN* DAY *7* YEAR *94*

---

[1] All italicized type indicates handwritten entries.

3B. Explain how your condition now keeps you from working.

Cannot communicate. Have difficulty naming objects, recalling names. Confusion in pronouns. Written communication does not make sense.

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

4. List the name, address and telephone number of the doctor who has the latest medical records about your disabling condition.

If you have no doctor check [ ]

NAME *Howard Fish, M.D.*

ADDRESS *2301 W. Parker Rd*
Suite 3
Plano, Tx. 75023

TELEPHONE NUMBER (include area code)
214-867-5226

HOW OFTEN DO YOU SEE THIS DOCTOR? *twice monthly*

DATE YOU **FIRST** SAW THIS DOCTOR *he was first consulted Jan 10*

DATE YOU **LAST** SAW THIS DOCTOR *Jan. 19*

REASONS FOR VISITS (show illness or injury for which you had an examination or treatment)

Also see Dr. Steven Herzog, Neurologist, twice monthly – Dr. Herzog treated patient at Baylor Hospital & will continue treatment Blood check every 2 wks.

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE".)

Speech therapy

5A. Have you seen any other doctors since your disabling condition began?

If "yes", show the following: [ ] YES [ ] NO

NAME *Dr. Steven Herzog*
712 N. Washington Av.

ADDRESS *712 N. Washington Ave.*
Dls. 75246

TELEPHONE NUMBER (include area code)
214-827-3610

HOW OFTEN DO YOU SEE THIS DOCTOR? *twice monthly*

DATE YOU **FIRST** SAW THIS DOCTOR *1-11*

DATE YOU **LAST** SAW THIS DOCTOR *1-13*

REASONS FOR VISITS (show illness or injury for which you had an examination or treatment)

Taken to Baylor Emergency Room for stroke related symptoms

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the

medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE".)

Tyclid for bloodthinner

5B. Identify below any other doctor you have seen since your illness or injury began.

NAME *Emergency Room Dr at Richardson Medical Hospital*

ADDRESS

TELEPHONE NUMBER (include area code)

HOW OFTEN DO YOU SEE THIS DOCTOR? *Emergency Rm only*

DATE YOU **FIRST** SAW THIS DOCTOR *1-8-94*

DATE YOU **LAST** SAW THIS DOCTOR *1-8-94*

REASONS FOR VISITS (show illness or injury for which you had an examination or treatment.)

Emergency Rm treatment

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE".)

Cat Scan/Bloodtests

6A. Have you been hospitalized or treated at a clinic for your disabling condition?

If "yes", show the following: [✓] YES [ ] NO

NAME OF HOSPITAL OR CLINIC *Baylor Hospital*

ADDRESS *3500 Gaston Ave*
Dls 75246

PATIENT OR CLINIC NUMBER

WERE YOU AN INPATIENT? (stayed at least overnight?)

[✓] YES [ ] NO (*If "yes", show:*)

WERE YOU AN OUTPATIENT?

[ ] YES [ ] NO (*If "yes", show:*)

DATES OF ADMISSIONS *1-11*

DATES OF DISCHARGES *1-13*

DATES OF VISITS

REASON FOR HOSPITALIZATION OR CLINIC VISITS (show illness or injury for which you had an examination or treatment.)

Stroke related tests

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE".)

tyclid –

MRI – arteriogram-blood tests

6B. If you have been in other hospital or clinic for your illness or injury, identify it below.

NAME OF HOSPITAL OR CLINIC *Richardson Medical Hosp.*

ADDRESS *401 W. Campbell*
Richardson 75080

PATIENT OR CLINIC NUMBER

WERE YOU AN INPATIENT? (stayed at least overnight?)

[ ] YES [✓] NO (If "yes", show:)

WERE YOU AN OUTPATIENT?

[ ] YES [✓] NO (If "yes", show:)

DATES OF ADMISSIONS

DATES OF DISCHARGES

DATES OF VISITS

REASON FOR HOSPITALIZATION OR CLINIC VISITS (show illness or injury for which you had an examination or treatment.)

Emergency Room treatment

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE".)

Catscan – Blood tests

If you have been in other hospitals or clinics for you illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI.

Have you been seen by other agencies for your disabling condition?

(VA, Workmen's Compensation, Vocational Rehabilitation, Welfare, etc.)

(If "yes," show the following.) [✓] YES [ ] NO

NAME OF AGENCY *Dls Co. Human Services*

ADDRESS *2377 N. Stemmons Frwy*
Suite 201, LB16
DLS 75207

YOUR CLAIM NUMBER *None-Assigned*

DATE OF VISITS *1-14-94*

TYPE OF TREATMENT, EXAMINATION OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicine you take for your illness or injury, if known, if no treatment or medicines, show "NONE".)

None

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part VI.

* * *

15C. Describe the kind and amount of physical activity this job involved during typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) – 0 [*1*] 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) – [*0*] 1 2 3 4 5 6 7 8
- **Sitting** (circle the number of hours a day spent sitting) – 0 1 2 3 4 5 6 [*7*] 8
- **Bending** (circle how often a day you had to bend) – Never – [*Occasionally*] – Frequently – Constantly
- **Reaching** (circle how often a day you had to reach) – [*Never*] – Occasionally – Frequently – Constantly

- **Lifting and Carrying**: Describe below what was lifted, and how far it was carried. Check heaviest weight lifted, and weight frequently lifted and/or carried: *N/A*

* * *

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law. I certify that the above statements are true.

NAME (Signature of claimant or person filing on the claimant's behalf)

SIGN HERE */s/ Carolyn Cleveland* DATE *1-21-94*

* * *

JAN 28 94
SSA D0814 DALLAS TX

APPLICATION FOR DISABILITY
INSURANCE BENEFITS

I APPLY FOR A PERIOD OF DISABILITY AND/OR ALL INSURANCE BENEFITS FOR WHICH I AM ELIGIBLE UNDER TITLE II AND PART A OF TITLE XVIII OF THE SOCIAL SECURITY ACT, AS PRESENTLY AMENDED.

MY NAME IS CAROLYN C CLEVELAND.

MY NAME AT BIRTH WAS CAROLYN COLLIER.

MY SOCIAL SECURITY NUMBER IS 530-26-0461.

MY DATE OF BIRTH IS AUGUST 17, 1935.

I BECAME UNABLE TO WORK BECAUSE OF MY DISABLING CONDITION ON JANUARY 07, 1994.

I AM STILL DISABLED.

NO PREVIOUS APPLICATION HAS BEEN FILED WITH THE SOCIAL SECURITY ADMINISTRATION BY OR FOR ME.

I HAVE NOT FILED NOR DO I INTEND TO FILE FOR ANY WORKERS' COMPENSATION, PUBLIC DISABILITY OR BLACK LUNG BENEFITS.

I AM NOT ENTITLED TO NOR DO I EXPECT TO BECOME ENTITLED TO A PENSION OR ANNUITY BASED IN WHOLE OR IN PART ON WORK AFTER 1956 NOT COVERED BY SOCIAL SECURITY.

THE SOCIAL SECURITY ADMINISTRATION AND THE STATE AGENCY REVIEWING MY CLAIM DOES HAVE MY PERMISSION TO CONTACT MY EMPLOYER(S).

TRC-803 (3/89)

I AM NOT MARRIED NOW.

* * *

I DO NOT HAVE ANY CHILDREN WHO MAY BE ELIGIBLE FOR SOCIAL SECURITY BENEFITS ON THIS RECORD

I UNDERSTAND THAT I MUST PROVIDE MEDICAL EVIDENCE ABOUT MY DISABILITY, OR ASSIST THE SOCIAL SECURITY ADMINISTRATION IN OBTAINING THE EVIDENCE.

I UNDERSTAND THAT I MAY BE REQUESTED BY THE STATE DISABILITY DETERMINATION SERVICES TO HAVE A CONSULTATIVE EXAMINATION AT THE EXPENSE OF THE SOCIAL SECURITY ADMINISTRATION AND THAT IF I DO NOT GO, MY CLAIM MAY BE DENIED.

I AUTHORIZE ANY PHYSICIAN, HOSPITAL, AGENCY, OR OTHER ORGANIZATION TO DISCLOSE ANY MEDICAL RECORD OR INFORMATION ABOUT MY DISABILITY TO THE SOCIAL SECURITY ADMINISTRATION OR TO THE STATE DISABILITY DETERMINATION SERVICES THAT MAY REVIEW MY CLAIM OR CONTINUING DISABILITY.

I AUTHORIZE THE SOCIAL SECURITY ADMINISTRATION TO RELEASE ANY INFORMATION ABOUT ME TO A PHYSICIAN OR MEDICAL FACILITY PREPARATORY TO AN EXAMINATION OR TEST. RESULTS OF SUCH EXAMINATION OR TEST MAY BE RELEASED TO MY PHYSICIAN OR OTHER TREATING SOURCE.

I AUTHORIZE THAT INFORMATION ABOUT MY DISABILITY MAY BE FURNISHED TO ANY CONTRACTOR FOR CLERICAL SERVICES BY THE STATE DISABILITY DETERMINATION SERVICES.

I AGREE TO NOTIFY THE SOCIAL SECURITY ADMINISTRATION OF ALL EVENTS AS EXPLAINED TO ME.

I AGREE TO NOTIFY THE SOCIAL SECURITY ADMINISTRATION IF:

- MY MEDICAL CONDITION IMPROVES SO THAT I WOULD BE able TO WORK, EVEN

THOUGH I HAVE NOT YET RETURNED TO WORK.

- I GO TO WORK WHETHER AS AN EMPLOYEE OR A SELF-EMPLOYED PERSON.

- I APPLY FOR OR RECEIVE A DECISION ON BENEFITS UNDER ANY WORKERS' COMPENSATION LAW OR PLAN (INCLUDING BLACK LUNG BENEFITS FROM THE DEPARTMENT OF LABOR), OR OTHER PUBLIC BENEFIT BASED ON DISABILITY.

- I AM IMPRISONED FOR CONVICTION OF A FELONY.

THE ABOVE EVENTS MAY AFFECT MY ELIGIBILTY TO [SIC] DISABILITY BENEFITS AS PROVIDED IN THE SOCIAL SECURITY ACT, AS AMENDED.

I AM NOT SUBMITTING EVIDENCE OF EARNINGS THAT ARE NOT YET ON MY EARNINGS RECORD. I UNDERSTAND THAT THESE EARNINGS WILL BE INCLUDED AUTOMATICALLY WITHIN 24 MONTHS, AND ANY INCREASE IN MY BENEFITS WILL BE PAID WITH FULL RETROACTIVITY.

I AGREE TO NOTIFY THE SOCIAL SECURITY ADMINISTRATION IF I BECOME ENTITLED TO A PENSION OR ANNUITY BASED ON EMPLOYMENT AFTER 1956 NOT COVERED BY SOCIAL SECURITY, OR IF SUCH PENSION OR ANNUITY STOPS.

MY REPORTING RESPONSIBILITIES HAVE BEEN EXPLAINED TO ME.

REMARKS:
MY EARNINGS ARE CORRECT AS POSTED. MY EARNINGS FELL TO $15,107 IN 1992 BECAUSE I DID NOT WORK PART OF THAT YEAR.

I KNOW THAT ANYONE WHO MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF MATERIAL FACT IN AN APPLICATION OR FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW BY FINE, IMPRISONMENT OR BOTH. I AFFIRM THAT ALL INFORMATION I HAVE GIVEN IN CONNECTION WITH THIS CLAIM IS TRUE.

MY MAILING ADDRESS IS 1806 SERENADE

RICHARDSON TX 75081

MY TELEPHONE NUMBER IS (214) 238-9150.

SIGNATURE /s/ *Carolyn Cleveland* DATE *1-26-94*

* * *

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

* * *

The reason for the release of this Medical information is to allow the recipient to evaluate my claim for benefits under the Social Security Act.

/s/ Carolyn Cleveland *self* *1-26-94*

* * *

[LOGO]
Texas
Rehabilitation
Commission
A Human Energy Agency

VERNON M. ARRELL
Commissioner

February 23, 1994

X 1st Request

Carolyn C. Cleveland
1806 Serenade
Richardson, TX 75081

SSN: 530 26 0461

Dear Mr./Ms. Cleveland:

The Social Security Administration has forwarded your disability file to this agency for medical development and decision. To help us properly evaluate your case, please complete the information on the attached form. Please

sign this form on the last page and return it to us within ten days. A postage-paid return envelope is enclosed for your use.

* * *

Sincerely,

/s/ Kathy Graves
Kathy Graves
Disability Examiner
(512) 445-8616

(IF THE REQUESTED INFORMATION IS NOT RECEIVED WITHIN TEN DAYS OF OUR SECOND REQUEST, A DECISION WILL BE MADE ON THE EVIDENCE IN FILE WHICH MAY RESULT IN A FINDING OF NO DISABILITY. IF YOU ARE RECEIVING CHECKS, THESE CHECKS MAY STOP.)

* * *

VOCATIONAL REPORT

[Original document stamped received by the SSA on March 22, 1994]

* * *

A. Name of Claimant
Carolyn C. Cleveland

B. Social Security Number
530-26-0461

PART I – INFORMATION ABOUT YOUR WORK HISTORY

* * *

JOB TITLE
(Be sure to begin with your usual job)
1. *Telephone Investigator*
2. *Employment Mgr.*

TYPE OF BUSINESS
1. *Checking past usually pre-emp.*
2. *Mfg*

DATES WORKED (Month and Year)			DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)
	FROM	TO		
1.	*4-31-93*	*1-7-94*	*M-F*	*8.31 hr.*
2.	*1-17-76*	*4-7-92*	*M-F*	*31,500 K*

* * *

PART II – INFORMATION ABOUT YOUR JOB DUTIES

Provide the following information (on pages 2-5) for each of the jobs listed in Part I starting with your usual job:

Job Title (from Part I):

A. In your job did you:
- Use machines, tools, or equipment of any kind?
[ ] Yes [✓] No

- Use technical knowledge or skills?
  [✓] Yes [ ] No
- Do any writing, complete reports, or perform similar duties?
  [✓] Yes [ ] No
- Have supervisory responsibilities?
  [✓] Yes [ ] No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:

1. *Calling past employers, education, credit, criminal history, interviews on phone.*

2.*Interview all applicants, pre-employment references, letters to applicants not hired, schedule drug testing, trained managers & supervisors. Responded to all unemployment insurance claims, prepared employment ads.*

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) –
  0 1 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) –
  0 1 2 3 4 5 6 7 8

- **Sitting** (circle the number of hours a day spent sitting) –
  0 1 2 3 4 5 6 7 8
- **Bending** (circle how often a day you had to bend) –
  Never – *Occasionally* – Frequently – Constantly

• **Lifting and Carrying:** Describe what was lifted, and how far it was carried. Check below heaviest weight lifted, and weight frequently lifted and/or carried. *None*

• • •

Job Title (from Part I):

A. In your job did you:
- Use machines, tools, or equipment of any kind?
  [✓] Yes [ ] No
- Use technical knowledge or skills?
  [✓] Yes [ ] No
- Do any writing, complete reports, or perform similar duties?
  [✓] Yes [ ] No
- Have supervisory responsibilities?
  [✓] Yes [ ] No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of

people you supervised and the extent of your supervision:

Telephone, computer, fax, a disability laws, employment laws, insurance.

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) –
  0 1 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) –
  0 1 2 3 4 5 6 7 8
- **Sitting** (circle the number of hours a day spent sitting) –
  0 1 2 3 4 5 6 7 8
- **Bending** (circle how often a day you had to bend) –
  Never – *Occasionally* – Frequently – Constantly

- **Lifting and Carrying:** Describe what was lifted, and how far it was carried. Check below heaviest weight lifted, and weight frequently lifted and/or carried. _____

• • •

1. Signature of Witness
   Carolyn Cleveland

Address (Number and street, city, state, and ZIP code)
1806 Serenade Ln. – Richardson, TX

_____

Claimant's Name
CLEVELAND, CAROLYN C
1806 SERENADE
RICHARDSON TX
DALLAS

Soc. Sec. Number

SUPPLEMENTAL QUESTIONNAIRE

This information will help us understand your condition and how it affects you. If you need more space to answer any question, there is room at the end of this form or you may attach extra pages.

1. Describe your symptoms (for example: pain, fatigue, weakness, shortness of breath, etc.). *headaches, weakness, shortness of breath*

   A. What brings on your symptoms or makes them worse? *Staying up for over three hours*

   B. If you have pain, where is it located? *head where stroke*

   C. How often do your symptoms occur, (per day, per week, etc.)? *per day*

   D. Have your symptoms changed since you began having them? YES [✓] NO [ ] If YES, describe how they have changed. *can stay up longer*

   E. How does your impairment affect your ability to complete routine activities or chores? Give examples. speech headache

2. Do you take medicine to relieve your symptoms? YES [✓] NO [ ]

A. If YES, what kind? *Tichid Zoloft (illegible)*

B. How much and how often do you take it? *daily*

C. Does your medicine help? YES [✓] NO [ ]. If YES, how much and for how long? *illegible*

D. Is there any reason you do not take your medicine? YES [ ] NO [✓]
If YES, explain. _____

3. Do you wear or use anything, other than medicine, to relieve your symptoms? YES [ ] NO [ ]. If YES, explain. *illegible*

4. Is there anything else you do to relieve your symptoms? *sleep*

5. What do you do for exercise? *grocery shopping, clean house, work outside*

6. Describe what you do on an average day, what takes most of your time during the day, etc. *breakfast, sleep until headache is gone, shower, dress, clean or straighten house, read ___ illegible, speech therapy, illegible, sleep, watch TV 4-5, wash clothes, dinner, read, sleep*

7. What activities are you not able to do now because of your symptoms that you were able to do in the past?
Work/Housework *yardwork, move furniture, change lightbulbs, clean as thorough*

Recreation *read, visit company, write letters*

Personal care (grooming, bathing, dressing, etc.) *none*

8. Do your symptoms affect your ability to perform any of the following activities? If YES, describe how.

YES	NO		
[✓]	[ ]	–	Sitting *not as long*
[✓]	[ ]	–	Standing *not as long*
[✓]	[ ]	–	Walking *not as long*
[✓]	[ ]	–	Lifting/Carrying *heavy sacks*
[ ]	[✓]	–	Using your hands _____
[ ]	[✓]	–	Bending _____
[✓]	[ ]	–	Kneeling, squatting _____
[✓]	[ ]	–	Climbing _____
[ ]	[✓]	–	Reaching forward _____
[✓]	[ ]	–	Working or reaching overhead ___
[✓]	[ ]	–	Hearing *not as well*
[✓]	[ ]	–	Speaking _____
[ ]	[✓]	–	Traveling to and from work _____
[ ]	[ ]	–	Reading the newspaper *sometimes*
[✓]	[ ]	–	Watching TV _____
[✓]	[ ]	–	Driving the car _____
[✓]	[ ]	–	Using the telephone _____

9. Please give your height *5'6"* and weight *164*. Is there anything else you wish to state about your condition? YES [ ] NO [ ]. If YES, state it here. *yes, have probably understanding long message or getting long numbers wright* [sic], could speak normal but impairing [sic.]

10. We may need to contact other people for information about your condition. Please list the names, addresses, and phone numbers of your spouse, relative(s) or friend(s) who are familiar with how your

condition affects your activities. If you have the names and phone numbers of additional persons we may contact, please list on the last page. (Do not list doctors.)

A. Name *Sheri Short*

Relationship *daughter*

Address *1800 Hilltop*
Arlington, TX

Daytime phone *817-884-2770*

Home phone *817-548-1460*

B. Name *Stephanie Hambrick*

Relationship *daughter*

Address *5605 illegible*
Rowlett, TX 75088

Daytime phone *illegible*

Home phone _____

11. Do you have any significant mental or emotional problems? YES [ ] NO [✓] If YES, explain. ____

12. Do your mental or emotional problems significantly affect your day to day living or work? YES [ ] NO [✓]. If YES, explain. _____

13. Have you ever received any mental or emotional treatment? YES [✓] NO [ ] If YES, what kind of treatment, where, when and by whom?. *alcoholics anonymous 3-14-92 – present*

14. Do you think that you need a mental or emotional evaluation in regard to your application for disability benefits? YES [ ] NO [✓]. Explain. _____

IF ANY OF THE ABOVE 4 QUESTIONS (#11-14) CONCERNING POSSIBLE MENTAL OR EMOTIONAL PROBLEMS WERE ANSWERED YES, PLEASE COMPLETE THE REMAINING PORTION OF THIS QUESTIONNAIRE. IF YOU ANSWERED NO TO ALL 4 QUESTION, STOP HERE. SIGN AND DATE THE LAST PAGE.

15. Do you have a counselor or social worker? YES [✓] NO [ ]. If YES, provide name, address, work, phone number, and date last seen. *3-7-94 Jesse Jordan – Dept. of Human Services, 2377 Stemmons Frwy., Suite 201-LB16, Dallas 75207, 214-819-1833*

16. Do you need another person's help, reminders or supervision in performing/completing any of the following activities? If YES, explain.

YES	NO	
[ ]	[✓]	– Bathing _____
[ ]	[✓]	– Brushing your teeth _____
[ ]	[✓]	– Fixing your hair _____
[ ]	[✓]	– Shaving _____
[ ]	[✓]	– Selecting appropriate clothing ____

YES	NO	
[ ]	[✓]	– Cooking _____
[✓]	[ ]	– Paying bills _____
[✓]	[ ]	– Visiting *at times*
[ ]	[✓]	– Shopping/making change _____
[✓]	[ ]	– Riding the bus _____
[✓]	[ ]	– Taking care of children *for short times*

17. Do you have difficulty keeping your mind or attention on a task/activity? YES [✓] NO [ ]. If YES, explain. _____

18. Do you have difficulty completing tasks? YES [✓] NO [ ]. If YES, explain. *yard, cleaning house*

19. Do you have problems making decisions? YES [✓] NO [ ]. If YES, explain. *fear of if I return to job*

20. What upsets you? *fear of returning to work*

21. When your daily routine changes, how do you react? *appreciate some change*

22. When you have stress/pressure, how do you react?

    At home *Calm down, ask for help and pray*

    When you worked *haven't returned*

    How often does it happen? _____

23. How do/did you get along with other people?

    At home *Well*

    When you worked *well*

24. What do you do when someone criticizes you or tells you what to do? *appreciate the help*

25. Is there anything else you wish to state about your mental or emotional condition and how it prevents you from working? YES [✓] NO [✓]. If YES, state it here.

    to speak well & retaining what I hear better

Signature of Claimant *Carolyn Cleveland* Date *3-16-94*

Form Completed By _____

Relationship to Claimant _____

* * *

DATE/FECHA: *4/20/94*

NAME: *Carolyn C. Cleveland* SSN: *530-26-0461*

THE SOCIAL SECURITY ADMINISTRATION HAS FORWARDED YOUR DISABILITY FILE TO THIS AGENCY FOR DEVELOPMENT AND DECISION. WE NEED ADDITIONAL INFORMATION WHICH ONLY YOU CAN SUPPLY. PLEASE CALL ME AT THE NUMBER SHOWN BELOW BETWEEN 9:00 A.M. AND 3:00 P.M. THIS CALL IS FREE FROM ANY TELEPHONE. IF YOU DO NOT RESPOND WITHIN 10 DAYS, THIS MAY RESULT IN A FINDING OF NO DISABILITY; OR IF YOU ARE RECEIVING CHECKS, THOSE CHECKS MAY STOP.

1-800-252-7009, EXT 8616

_____

DISABILITY EXAMINER/EXAMINADOR(A) DE INCAPACIDAD; UNIT/UNIDAD; NO.

Pls call me immediately regarding your current doctors and when you were last seen. I have already left 2 mssgs for you.

* * *

DATE/FECHA: *4/20/94*

NAME: *Carolyn C. Cleveland* SSN: *530-26-0461*

THE SOCIAL SECURITY ADMINISTRATION HAS FORWARDED YOUR DISABILITY FILE TO THIS AGENCY FOR DEVELOPMENT AND DECISION. WE NEED ADDITIONAL INFORMATION WHICH ONLY YOU CAN SUPPLY. PLEASE CALL ME AT THE NUMBER SHOWN BELOW BETWEEN 9:00 A.M. AND 3:00 P.M. THIS CALL IS FREE FROM ANY TELEPHONE. IF YOU DO NOT RESPOND WITHIN 10 DAYS, THIS MAY RESULT IN A FINDING OF NO DISABILITY; OR IF YOU ARE RECEIVING CHECKS, THOSE CHECKS MAY STOP.

None were received.

1-800-252-7009, EXT 8616

DISABILITY EXAMINER/EXAMINADOR(A) DE INCAPACIDAD; UNIT/UNIDAD; NO.

Pls call me immediately regarding your current doctors and when you were last seen. I have already left 2 mssgs for you.

* * *

4-23-94.

Have tried to contact Kathy Graves and have been unable to reach her. I did return to work in April.

Carolyn Cleveland

Social Security
Notice of Disapproved Claim

From: Department of Health and Human Services
Social Security Administration

Date: 07/11/94

Caroly C. Cleveland
1806 Serenade
Richardson, TX 75081

Claim Number: 530-26-0461

We have determined that you are not entitled to disability insurance benefits because you cannot be considered under a disability within the meaning of the law. It has been determined from the evidence that the work you are

doing despite your handicap shows you are able to do some type of substantial gainful work. Attached to this notice is an explanation of the decision we made on your claim and how we arrived at it.

* * *

DISABILITY DETERMINATION RATIONALE

Name of Claimant
Carolyn Cleveland

SSN
530-26-0461

We have received notification that you began working full time as of April 21, 1994 with earnings greater than $500 per month. We understand that this work is continuing and that you fully earn your salary.

Work activity for earnings which average more than $500.00 per month is generally considered substantial gainful activity. Your claim must be denied because you are working and fully earning more than $500.00 per month.

CLAIM REP (DO-BGA DETERM)
ILLEGIBLE

Date
7/11/94

[LOGO]

General Information Services
A Division of Policy Management Systems Corporation

12377 Merit Drive, Suite 800 • Dallas, TX 75251
P.O. Box 517018 • Dallas, TX 75251-7018
(214) 702-3845 • FAX (214) 934-0647

June 3, 1994

To: Carolyn Cleveland

From: Debra Levine

Re: Trainee status/Performance evaluation

Carolyn,

This is to inform you that your status as a Trainee is nearing an end. The normal time span that an employee is in training is three to six months. You have been with GIS for nine months; however, I have taken into account that you were out for three months.

There are some concerns as to your performance as an Inspector. The focus for the majority of those concerns is the fact that you don't seem to be consulting the CIF (Client Information Form) for each client before beginning work on each case. This is a necessity for all inspectors, due to the fact that each client has such different requirements.

Another concern is that many of your reports either include too much information, or are missing necessary information. I feel that this would be rectified by consulting the CIF before working each report. I believe that we have addressed and hopefully solved the problem concerning the summaries and status due most of the clients.

Carolyn, I know that you have been trying hard and feel that you have been doing the best you can, but the number of cases that you complete is not acceptable. You must strive to improve the quality and quantity of the reports you work.

This evaluation is to enlighten you to some of the problems I have encountered with your work, and to inform you of some upcoming changes.

At the end of this month, on June 30, 1994, your employee status will be subject to change to that of a Fee Inspector. However, if there are not some drastic changes in the quality of work that you produce, you are subject to be separated from the company.

/s/ *Carolyn Cleveland* 6-3-94
Carolyn Cleveland Date

/s/ *Debra Levine* 6/3/94
Debra Levine, Report Supervisor Date

June 21, 1994

To: Carolyn Cleveland

From: Debra Levine

Re: Extension of Training Period

Carolyn, per your request dated June 9, 1994, I am extending your training period. I am willing to work with you as much as is necessary in order to improve the quality and quantity of your work. However, please understand that this is the final extension I can approve.

Therefore, on August 1, 1994, the same status changes discussed previously (moving to a fee reporter status or separation from the company) will be determined.

I have seen some improvement; however, I cannot stress enough how important it is that the improvement continue.

/s/ *Carolyn Cleveland* *6-21-94*
Carolyn Cleveland Date

/s/ *Debra Levine* *6/21/94*
Debra Levine, Report Supervisor Date

THE DALLAS NEUROLOGICAL CLINIC
712 N. Washington, Suite 100
Dallas, Texas 75246
(214) 827-3610

July 26, 1994

EEOC

Re: Carolyn Cleveland

To Whom It May Concern:

Ms. Carolyn Cleveland is a patient of mine at The Dallas Neurological Clinic. I initially saw her on 1/11/94 at which time she had had a stroke in the left cerebrum affecting her language functioning. This left her with an aphasia. An aphasia is a disorder of input and output of language which affects one's reading ability, calculation ability, understanding and processing of all language function. Luckily, no further complications ensued from this stroke, and the patient was discharged in stable condition. She was left with the prominent aphasia as noted above.

At this time, some of the difficulties that we encountered upon returning to work were fear in making phone calls and forgetting the right words, fear of pressure on the phone, and fear of not having other people understand her. She was unable to retain information and facts that were not written down. She had trouble writing of reports and difficulty remembering some of the words needed and the correct spelling. She had absolutely no training in this particular type of work prior to the stroke that required changing particular job requirements. Remaining difficulties up to termination included cruel remarks and jokes about the patient's "little stroke," the

fact that she was off work for so "long a time" if no severe stroke had occurred, and mimicking and making fun of my patient, needing telephone numbers and some addresses repeated, difficulty with long numbers and extra time to double check, not allowed extra time to keep up with her work, and refused extra time. The Texas Disability Commission offered a person to come to her office to validate the problems after the stroke and provide some assistance. This was refused on two separate occasions by the patient's supervisor and on two separate occasions by the manager.

At the present time, she is much better with phone calls. They were no problems toward the end of her employment through 7/15/94. She could communicate more easily. Her spelling had improved, even with more difficult words. She had to recheck and recheck for any errors, but this was a problem which was improving. She taught herself without any particular training. She was making very few errors and made no errors at all while Debra, the supervisor, was on vacation the week prior to her termination.

On 6/21/94, Carolyn received a letter from Debra Levine regarding her extension of training period. We are enclosing a copy of this letter for your review.

IMPRESSION: Status post cerebrovascular accident (stroke) left cerebrum with resultant damage to the language center. Ms. Cleveland is continuing to improve with time, and as you can assume it sometimes takes 6-12 months to get a full recovery from a stroke. She has worked very hard to retain her job, and it appears that they were not as cooperative as could be. Obviously, I

have not spoken with any of the supervisors at work, nor reviewed a job requirement or job description as of this date. It is evident to me that my patient was trying her best to retain employment, to keep being a useful member of society, even in face of this new disability. Please assist her in every way possible.

Sincerely,

Steven P. Herzog, M.D.
Enclosure: Letter form Debra Levine

THE DALLAS NEUROLOGICAL CLINIC
712 N. Washington, Suite 100
Dallas, Texas 75246
(214) 827-3610

September 9, 1994

Re: Carolyn Cleveland

To Whom It May Concern:

Ms. Carolyn Cleveland is a patient of mine at The Dallas Neurological Clinic. She suffered with a stroke on 1/7/94 causing aphasia. This has produced complete disability and an inability to communicate on a sustained, continuing, understandable level. For this reason, I am classifying her as 100% disabled.

Sincerely,

/s/ *Steven P. Herzog*
Steven P. Herzog, M.D.

NH 530-26-0461 SG-SSA-56 PAGE 001

UNIT: 5PXPXS

REQUEST FOR RECONSIDERATION

MY NAME IS CAROLYN C CLEVELAND.

MY SOCIAL SECURITY NUMBER IS 530-26-0461.

I REQUEST A RECONSIDERATION. I DISAGREE WITH THE DETERMINATION MADE ON MY CLAIM FOR DISABILITY-WORKER OR CHILD BENEFITS BECAUSE I WAS DENIED BECAUSE I HAD RETURNED TO WORK AND WAS MAKING OVER $500. HOWEVER, ON JULY 15, 1994 I WAS TERMINATED DUE TO MY CONDITION AND I HAVE NOT BEEN ABLE TO WORK SINCE. I CONTINUE TO BE DISABLED.

I AM SUBMITTING ADDITIONAL EVIDENCE WITH THIS REQUEST.

I UNDERSTAND I HAVE A RIGHT TO BE REPRESENTED AT THE RECONSIDERATION.

SIGNATURE /s/ *Carolyn Cleveland* APPELLANT

MY ADDRESS IS 1806 SERENADE
RICHARDSON TX 75081

MY PHONE NUMBER IS 214-238-9150.

DATE SEPTEMBER 14, 1994.

WORK ACTIVITY REPORT – EMPLOYEE

Name of disabled person: *Carolyn Cleveland*

* * *

5. If either statement below applies to all jobs shown in item 2, please check:

   a. I worked 3 months or less and stopped because of my injury or illness. [✓]

   b. I continued or returned to work for the same amount or more money and my duties and my work hours are the same as before my illness. [ ]

* * *

10. Use this section for additional space to answer any previous questions and to give any additional information you think will be helpful. Please refer to the previous questions by number, such as 4 (other earnings), 7 (job requirements).

I had my stroke 1/7/94 and was out of work for several months. I attempted to return to work mid April. I worked for three months before they terminated me because I could no longer do the job because of my condition.

If more space is needed, use an extra sheet.

1. Check the appropriate block below:

   [✓] I am not receiving Social Security and/or Supplemental Security income disability benefits.

   [ ] I am receiving Social Security and/or Supplemental Security income disability benefits, and I understand that the information provided above may result in my benefits being stopped. I have been given the opportunity to submit any evidence I wanted and to make any statements concerning my claim.

Please read the following statement then sign and date, provide address and telephone number.

Knowing that anyone who makes a false statement or misrepresentation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I affirm that the answers to questions on this form are true.

A. Signature of claimant/beneficiary or representative
Carolyn C. Cleveland

B. Date
9-20-94

C. Telephone no. & area code
(214) 238-9150

D. Mailing address, (Number and street, apt. no., p.o. box, or rural route.)
1806 Serenade

E. City and state
Richardson, TX

F. Zip code
75081

G. County
Dallas

12. A. Contact made

[ ] In Person
[ ] By Mail
[✓] By Telephone

B. Completed by

[ ] Claimant
[✓] SSA Representative
[ ] Other

If other, show name, address, phone number, and relationship.

13. Interviewer/Reviewer Check List ("Yes" answers should be developed in accordance with DI00503 FF. Rationalize "Yes" or "No" answers below except when it is necessary to complete the SSA-831-U5, SSA-832-U5 or SSA-833-U5) Check all that apply:

a. Subsidy (specific or non-specific)
[ ] Yes [✓] No

b. Special considerations, situations, or assistance
[ ] Yes [✓] No

c. Impairment-related work expenses
[ ] Yes [✓] No

d. Mentally handicapped individual performs simple task subject to close supervision
[ ] Yes [✓] No

e. Unsuccessful work attempt (CDR-no medical issue – DO jurisdiction for a final determination)
[ ] Yes [✓] No

f. Unsuccessful work attempt (DO recommendation only – DDS jurisdiction for a final determination)
[✓] Yes [ ] No

g. Substantial gainful activity
[ ] Yes [✓] No

h. Trial work period (reminder item)
[ ] Yes [✓] No

* * *

RATIONALE: *Clmt's work lasted only three months and ended due to her condition – UWA.*

4. Remarks

5. Signature and title of SSA interviewer or reviewer
P. Illegible CR

16. DO code
814

17. Date
9/20/94

Claimant's Name *Carolyn Cleveland*

Soc. Sec. Number *530-26-0461*

SUPPLEMENTAL QUESTIONNAIRE

This information will help us understand your condition and how it affects you. If you need more space to answer any question, there is room at the end of this form or you may attach extra pages.

1. Describe your symptoms (for example: pain, fatigue, weakness, shortness of breath, etc.). *fatigue, difficulty w/verbal communication & written communication due to stroke. Have trouble w/comprehension – also have ashma* [sic]

   A. What brings on your symptoms or makes them worse? *stress, ozone or dust*

   B. If you have pain, where is it located? *headaches – frequent back pain*

   C. How often do your symptoms occur, (per day, per week, etc.)? *3-4 times per wk*

   D. Have your symptoms changed since you began having them? YES [ ] NO [ ] If YES, describe how they have changed. *same*

   E. How does your impairment affect your ability to complete routine activities or chores? Give examples. *can't stand for long periods, verbal & written communication affects ability to make phone calls, complete paper work & similar tasks. Slow to comprehend any form of communication, difficulty breathing*

2. Do you take medicine to relieve your symptoms? YES [✓] NO [ ]

A. If YES, what kind? *(illegible)*

B. How much and how often do you take it? *daily*

C. Does your medicine help? YES [✓] NO [ ]. If YES, how much and for how long? *prevent blood from clotting – easier breathing – reduce headaches – anxiety illegible*

D. Is there any reason you do not take your medicine? YES [ ] NO [✓]

If YES, explain. _____

3. Do you wear or use anything, other than medicine, to relieve your symptoms? YES [ ] NO [✓]. If YES, explain. _____

4. Is there anything else you do to relieve your symptoms? *stay indoors on ozone alert days*

5. What do you do for exercise? *walk – limited housework*

6. Describe what you do on an average day, what takes most of your time during the day, etc. *routine tasks – make & keep appts w/government agencies, doctors assist other stroke victims and the stroke recovery group*

7. What activities are you not able to do now because of your symptoms that you were able to do in the past?
Work/Housework *find work related to my experience, human resources, personnel*

Recreation *do most of the same things just less times*

Personal care (grooming, bathing, dressing, etc.) *no problem*

8. Do your symptoms affect your ability to perform any of the following activities? If YES, describe how.

YES	NO		
[ ]	[✓]	–	Sitting _____
[✓]	[ ]	–	Standing *for long periods*
[✓]	[ ]	–	Walking *for long periods*
[✓]	[ ]	–	Lifting/Carrying _____
[ ]	[✓]	–	Using your hands _____
[ ]	[✓]	–	Bending _____
[✓]	[ ]	–	Kneeling, squatting _____
[✓]	[ ]	–	Climbing _____
[ ]	[✓]	–	Reaching forward _____
[✓]	[ ]	–	Working or reaching overhead ___
[✓]	[ ]	–	Hearing _____
[✓]	[ ]	–	Speaking _____
[ ]	[ ]	–	Traveling to and from work *NA*
[✓]	[ ]	–	Reading the newspaper *comprehension*
[✓]	[ ]	–	Watching TV *comprehension*
[ ]	[✓]	–	Driving the car _____
[✓]	[ ]	–	Using the telephone *difficulty communicating*

9. Please give your height *5'6"* and weight *170*. Is there anything else you wish to state about your condition? YES [ ] NO[✓]. If YES, state it here.

10. We may need to contact other people for information about your condition. Please list the names, addresses, and phone numbers of your spouse, relative(s) or friend(s) who are familiar with how your

condition affects your activities. If you have the names and phone numbers of additional persons we may contact, please list on the last page. (Do not list doctors.)

A. Name *Sheri Short*

Relationship *daughter*

Address *1800 Hilltop*
Arlington, TX 76013

Daytime phone *(817) 548-1460*

Home phone *same*

B. Name *Susan Moynahan*

Relationship *daughter*

Address *14777 illegible #410*
Houston, TX illegible

Daytime phone *(713) 587-2028*

Home phone *same*

11. Do you have any significant mental or emotional problems? YES [✓] NO [ ] If YES, explain. *just symptoms already described*

12. Do your mental or emotional problems significantly affect your day to day living or work? YES [✓] NO [ ]. If YES, explain. *already described*

13. Have you ever received any mental or emotional treatment? YES [ ] NO [✓] If YES, what kind of treatment, where, when and by whom?. _____

14. Do you think that you need a mental or emotional evaluation in regard to your application for disability benefits? YES [ ] NO [✓]. Explain. _____

IF ANY OF THE ABOVE 4 QUESTIONS (#11-14) CONCERNING POSSIBLE MENTAL OR EMOTIONAL PROBLEMS WERE ANSWERED YES, PLEASE COMPLETE THE REMAINING PORTION OF THIS QUESTIONNAIRE. IF YOU ANSWERED NO TO ALL 4 QUESTION, STOP HERE. SIGN AND DATE THE LAST PAGE.

15. Do you have a counselor or social worker? YES [ ] NO [✓]. If YES, provide name, address, work, phone number, and date last seen.

16. Do you need another person's help, reminders or supervision in performing/completing any of the following activities? If YES, explain.

YES	NO		
[ ]	[✓]	–	Bathing _____
[ ]	[✓]	–	Brushing your teeth _____
[ ]	[✓]	–	Fixing your hair _____
[ ]	[✓]	–	Shaving _____
[ ]	[✓]	–	Selecting appropriate clothing ____
[ ]	[✓]	–	Cooking _____
[✓]	[ ]	–	Paying bills *comprehension*
[ ]	[✓]	–	Visiting *some problems w/ people I don't know*
[ ]	[✓]	–	Shopping/making change _____
[ ]	[✓]	–	Riding the bus _____
[ ]	[✓]	–	Taking care of children _____

17. Do you have difficulty keeping your mind or attention on a task/activity? YES [✓] NO [ ]. If YES, explain. *occasionally*

18. Do you have difficulty completing tasks? YES [✓] NO [ ]. If YES, explain. *in a timely manner due to length of time it takes to complete the task*

19. Do you have problems making decisions ? YES [✓] NO [ ]. If YES, explain. *ability to analyze situation*

20. What upsets you? *the frustration of not being able to communicate & perform tasks*

21. When your daily routine changes, how do you react? *OK*

22. When you have stress/pressure, how do you react?

    At home *ability to communicate is increasingly difficult*

    When you worked *same & became emotional*

    How often does it happen? *not very often now – when I was working – daily*

23. How do/did you get along with other people?

    At home *good*

    When you worked *good*

24. What do you do when someone criticizes you or tells you what to do? *welcome positive criticism – in my situation feel I need direction*

25. Is there anything else you wish to state about your mental or emotional condition and how it prevents you from working? YES [ ] NO [✓]. If YES, state it here.
    Signature of Claimant *Carolyn Cleveland* Date *9-29-94*

Form Completed By *Sheri Short*

Relationship to Claimant *daughter*

Cary A. Conaway Ph.D. 520 E. Central Park #222
Plano, TX. 75074
TEL 214/670-3104

NAME: Cleveland, Carolyn C.
DOB: 08-17-35
AGE: 59
SSN: 530-26-0461
EVALUATION DATE: 11-03-94

I. CHIEF COMPLAINT

When asked why she was at the examination, Ms. Cleveland said, "To get my disability." When asked why she had applied for disability benefits Ms. Cleveland responded, "I had a stroke in January of 1994; I went back to work but I couldn't work."

* * *

VII. PROGNOSIS

Some improvement in her current functioning is anticipated. This condition has shown steady progress and response to treatment has been favorable. Although language functions are still affected she could communicate easily. She reports that language is better if she is completely rested. She reports being well rested at the time of the evaluation.

VIII. CAPABILITY

Ms. Cleveland is considered competent to manage benefits and make financial decisions.

/s/ *Cary A. Conaway* — *11-13-94*
Cary A. Conaway, Ph.D. — Date

[Logo]
Texas
Rehabilitation
Commission
"A Human Energy Agency"

VERNON M. ARRELL
Commissioner

Dallas Northeast Field Office
6500 Greenville Ave., Suite 250
Dallas, Texas 75206

Telephone (214) 692-1665
Fax (214) 891-0841

Carol Cleveland
1806 Serenade Lane
Richardson, Tx 75081

Dear Carol:

After reviewing all available information, it has been determined that you are ineligible for Vocational Rehabilitation Services for the following reasons:

__X__ Vocational Rehabilitation Services will not benefit you in terms of an employment outcome.

____ You do not have a physical or mental disability which results in a substantial impediment to employment.

____ Vocational Rehabilitation Services are not required.

This decision is based on information obtained from the preliminary and comprehensive assessments and is subject to appeal as explained at the time you applied for Vocational Rehabilitation Services. If you desire to arrange for an appeal, please contact me at this office for assistance. The Client Assistance Program is available should you need additional help in understanding this determination or in appealing it.

11-7-94 — /s/ *Illegible*
Date — Counselor

TEXAS REHABILITATION COMMISSION

AMENDMENT TO THE INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM (IWRP) (CERTIFICATION OF INELIGIBILITY)

Client Name: *Carolyn Cleaveland* [sic]

Date: *11/7/94*

This change to your IWRP records that, based on a review of all available information, you are not able to achieve and employment outcome and; therefore, are not eligible for Vocational Rehabilitation services.

The Counselor's reason(s) for an ineligibility Determination: If the reason for case closure is disability too severe, describe the demonstration by clear and convincing evidence that the individual is not capable of achieving an employment outcome (attach additional sheets if needed):

The closure as disability too severe is based on clients request & supported by existing Medical records & counselor clinical assessment. Ms. Cleaveland [sic] *reports severe physical & cognitive limitation which will interfere with her ability to find & keep employment.*

Your (client's) opinion and/or any representative's opinion of this Determination of ineligibility (attach additional sheets if needed):

Ms. Cleaveland [sic] agrees with the assessment and would like her case to be closed.

This determination of ineligibility has been made with full participation of you and, if appropriate, your parent, guardian, or other representative.

A copy of this document was given to you on: *11/7/94* (date)

Your Rights of Appeal, including the right to an annual review of this decision, have been explained to you and you realize that the first step in appealing an ineligibility decision, after talking with your counselor, is to give your counselor the complaint in writing.

If you have questions or concerns about this decision, you may call the Texas Rehabilitation Commission's Assistance and Referral Services office (1-800-628-5115) or you may call the Client Assistance Program (1-800-223-4206).

Counselor's Signature
/s/ *Illegible*

Date:
11/7/94

Social Security Administration
Retirement, Survivors, and Disability Insurance
Notice of Disapproved Claim

Telephone: 214 767-9931

Date: NOV 30 1994

Claim Number: 530 26 0461

Carolyn Cleveland
1806 Serenade
Richardson, TX 75081

We are writing about your claim for Social Security disability benefits. Based on a review of your health problems you do not qualify for benefits on this claim. This is because you are not disabled under our rules.

* * *

Noel D. Wall, Dallas
Regional Commissioner

* * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

EXPLANATION OF DETERMINATION

Name of Claimant	SSN	Type of Claim
Carolyn Cleveland	530-26-0461	DIB

The determination on your claim w[illegible] made by an agency of the State, Doctors and other people in the State Agency who are trained in disability evaluation reviewed the

evidence and made the determination based on Social Security law and regulations. The determination was not made by your own doctor or by other people or agencies writing reports about you. However, any evidence they gave us was used in making this determination.

The following information was used to decide your claim:

Steven Herzog, M.D., reports dated 1/11/94 to 9/20/94; Richardson Medical Center, reports dated 1/8/94; Baylor University Medical Center, reports dated 1/11/94 to 1/13/94; Malladi R. Sastry, M.D., reports dated 10/21/81 to 4/11/94; Parkside Hospital, reports dated 3/14/93 to 4/15/93; Cary A. Conaway, Ph.D., report of full battery psychological consultative examination dated 11/3/94.

We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training and work experience in determining how your condition affects your ability to work. You said you were disabled because of a stroke causing speech problems. However, you have made a good recovery. Reports show that you have some difficulty understanding and remembering complex instructions. Most of the time you are able to think clearly and carry out normal activities. Although you do have speech problems, you can be understood by others. The evidence does not show any other health problems that cause significant limitations. Although a return to work done in the past is not possible, your condition does allow other less demanding work. This conclusion takes into consideration your age, education, and work history. If your condition gets worse

and keeps you from working, write, call, or visit any Social Security office.

THE GANT CLINIC
9400 N. Central Expressway
Suite #1305
Dallas, Texas 75231

Bob L. Gant Ph.D.
Fellow, American Academy of Psychosomatic Medicine
Diplomate, American Board of Professional Neuropsychology
Diplomate, American Academy of Pain Management

Voice: (214) 361-6092
Fax: (214) 361-5429
Internet: GANT01@UTSW.SWMED.EDU

The following letter is strictly CONFIDENTIAL and is for the information of the person to whom it is addressed. No responsibility can be accepted if it is made available to another person, INCLUDING THE PATIENT.

January 4, 1995

Stephen Herzog, MD
712 N. Washington
Dallas, Texas

RE: Patient's Name: Carolyn Cleveland
Social Security Number: 530-26-0461

Dear Dr. Herzog,

Thank you for referring Carolyn Cleveland for neuropsychological testing and psychological treatment. The

patient's insurance company has been kind enough to pre-authorize these services and we are in the midst of the evaluation at this time. I did an intake interview with the patient today. While she is not a completely accurate historian, she did relate to me a history of some type of stroke earlier this year. It was her belief that the stroke was localized to the left hemisphere. We have taken the liberty of obtaining permission to view her medical records which will further clarify the nature of this event and the medical consequences.

Psychologically, things have been a mess. The patient was fired shortly after returning to work. Her rehabilitation counselor had offered the company assistance in accommodating her disability but, according to Ms. Cleveland, this was to no avail. The loss of her job and income have been emotionally devastating.

Observations of the patient suggest that she is suffering from an organic affective disorder. She displays word finding difficulty, emotional lability, and is easily confused. It is presumed that her altered mental status is a function of the aforementioned CVA-type event.

At this point, a full neuropsychological evaluation is contemplated. The patient has also bee [sic] approved for supportive psychotherapy sessions. I presume this is the basis for your referral and hope that we have complied

with your wishes. Thank you very much for referring this patient to us.

Best Personal Regards,

/s/ *Bob L. Gant Ph.D.*
Bob L. Gant, Ph.D. FAPM

BLG/bmh

cc: Dr. Fish

Letter has been dictated, but not proofread. Transcription variances may occur.

THE GANT CLINIC
9400 N. Central Expressway
Suite #1305
Dallas, Texas 75231

Bob L. Gant Ph.D.
Fellow, American Academy of Psychosomatic Medicine
Diplomate, American Board of Professional Neuropsychology
Diplomate, American Academy of Pain Management

Voice: (214) 361-6092
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Internet: GANT01@UTSW.SWMED.EDU

NEUROPSYCHOLOGICAL EVALUATION

Patient Name:	Carolyn Cleveland
DOB:	8-17-35
Age:	59 years
SS #:	530-26-0641
DOS:	1-9-95
Referring Physician:	Stephen Herzog, MD
Psychometrist:	Pennissi P. Taylor, M.S.
Psychologist:	Bob L. Gant, Ph.D.

IDENTIFICATION AND REFERRAL INFORMATION

Carolyn Cleveland is a fifty-nine-year old Caucasian female. Ms. Cleveland has been divorced since 1983. She was referred for a neuropsychological evaluation by Dr. Herzog due to Ms. Cleveland's report of emotional lability and severe memory difficulties. Ms. Cleveland applied for Social Security Disability but has been denied. At the current time, Carl Weisbrod is representing Ms. Cleveland in her appeal of the disability denial.

* * *

DISABILITY RATING

Based on the AMA Guide to Disability Determination, 3rd Edition, 2nd Printing (February, 1989), Ms. Cleveland would, in my estimation be classified under a marked disability rating based on my analysis of the available data. This is taken from page 241 of the guide using Table 1 in Chapter 14. Based on this evaluation, the patient is permanently disabled.

SUMMARY AND CONCLUSIONS

Carolyn Cleveland is a fifty-nine-year-old divorced Caucasian female who presented to the Gant Clinic for a neuropsychological evaluation following a stroke which occurred in January of 1994. Based on this evaluation, Ms. Cleveland is currently moderately neuropsychologically impaired. She has several significant indicators of brain

dysfunction including difficulties with abstract and psychomotor problem solving verbal and non-verbal auditory discrimination, impaired motor skills, impaired word finding and speech difficulties as well as significant verbal and figural memory problems. Ms. Cleveland has consequently become severely depressed in relation to her current situation and decreased level of functioning.

* * *

Best Personal Regards,

/s/ *Bob L. Gant, Ph.D.*
Bob L. Gant, Ph.D. FAPM
Supervising Psychologist

PT/bmh

Date of Dictation: 1-24-95, 1-25-95
Date of Transcription: 1-27-95

cc: Dr. Herzog
Dr. Fish

THE GANT CLINIC
9400 N. Central Expressway
Suite #1305
Dallas, Texas 75231

Bob L. Gant Ph.D.
Fellow, American Academy of Psychosomatic Medicine
Diplomate, American Board of Professional Neuropsychology
Diplomate, American Academy of Pain Management

Voice: (214) 361-6092
Fax: (214) 361-5429
Internet: GANT01@UTSW.SWMED.EDU

The following letter is strictly CONFIDENTIAL and is for the information of the person to whom it is addressed. No responsibility can be accepted if it is made available to another person, INCLUDING THE PATIENT.

January 23, 1995

Stephen Herzog, MD
712 NW Washington
Dallas, Texas

RE: Carolyn Cleveland
SS#: 530-26-0461

Dear Dr. Herzog,

As you know, Carolyn Cleveland is a fifty-nine-year-old Caucasian female who reportedly suffered a stroke in January of 1994. The patient was sent to me for neuropsychological testing and treatment. The neuropsychological testing has now been completed and a report will be sent to you under separate cover.

Based on our findings, the patient does appear to have suffered neuropsychological damage as a presumed result of her stroke. It is also reported that the patient has a history of alcoholism. Currently, the patient is also suffering from depression which I understand you are treating with Zoloft.

As you know, psychologically, things for the patient have been a mess. The patient was fired shortly after returning to work. The loss of her job and income have been emotionally devastating and have compounded her injury by affecting her self confidence and self esteem.

While the effects of the patient's stroke are relatively permanent, I do think that we can help her psychologically with some emotional support. I am going to recommend to the patient that she attend some psychological counseling sessions. The patient is in agreement with this.

I hope that this plan meets with your approval.

Best Personal Regards,

/s/ *Bob L. Gant, Ph.D.*
Bob L. Gant, Ph.D., FAPM

THE GANT CLINIC
9400 N. Central Expressway
Suite #1305
Dallas, Texas 75231

Bob L. Gant Ph.D.
Fellow, American Academy of Psychosomatic Medicine
Diplomate, American Board of Professional Neuropsychology
Board Certified Forensic Examiner
Fellow, American Back Society
Diplomate, International Academy of Behavioral Medicine

Voice: (214) 361-6092
Fax: (214) 361-5429
Internet: GANT01@UTSW.SWMED.EDU

May 12, 1995

Dr. Steven P. Herzog
Dallas Neurological Clinic
712 North Washington, Suite 100
Dallas, Texas 75246

RE: Carolyn Cleveland

Dear Dr. Herzog,

I hope that you received our neuropsychological evaluation which was completed on 1-6-95 for Carolyn. Based on our neuropsychological evaluation, I believe this

patient is permanently and completely disabled from any productive work. She suffers significant neuropsychiatric as well as neurocognitive deficits which render he [sic] unable to be gainfully employed. I understand that her Social Security Application has been denied. This is somewhat surprising to me in that it is my understanding that Social Security utilizes results such as those obtained on the Halstead-Reitan Neuropsychological Test Battery when making their determination. It is interesting to note that I was never contacted by the disability examiner during the disability determination process, as usually is the practice. I wonder if they have been cognoscente [sic] of this lady's plight?

I am sending a copy of this letter to the patient's attorney, Carl Weisbraud [sic]. Mr. Weisbraud [sic] is one of the top Social Security attorneys in this part of the country. I am sure he will aggressively pursue assistance for this patient. I think she is in desperate need of his assistance.

The patient has been attending her therapy sessions at my clinic on a faithful basis. She is extremely depressed, and I believe she is suffering from an organic brain syndrome. We have been trying to get the patient to see a psychiatrist who specializes in treating patients with organic brain syndromes, Dr. Jay Seastrunk. I trust this plan meets with your approval.

Thank you for allowing us to participate in this patient's care.

Best Personal Regards,

Bob L. Gant, Ph.D., FAPM

BLG/bmh

cc: Carl Weisbraud
Carolyn Cleveland
Jay Seastrunk

Letter has been dictated, but not proofread.
Transcription variances may occur.

REQUEST FOR RECONSIDERATION

* * *

NAME OF CLAIMANT
Carolyn C Cleveland

SOCIAL SECURITY CLAIM NUMBER
530-26-0461

SPOUSE'S NAME (*Complete ONLY in SSI cases*)

CLAIM FOR (*Specify type, e.g., retirement, disability, hospital insurance, SSI, etc.)*
disability

* * *

I do not agree with the determination made on the above claim and request reconsideration. My reasons are:

I am unable to work due to my disability.

* * *

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE
/s/ *Carl Weisbrod*
Carl Weisbrod
[ ] NON-ATTORNEY
[X] ATTORNEY

STREET ADDRESS
P.O. Box 821329

CITY	STATE	ZIP CODE
Dallas	TX	75382

TELEPHONE NUMBER *(include area code)*
(214) 373-3761

DATE
01/09/95

CLAIMANT SIGNATURE
/s/ *Carolyn Cleveland*

STREET ADDRESS
1806 Serenade

CITY	STATE	ZIP CODE
Richardson	*Tx*	*75081*

TELEPHONE NUMBER *(Include area code)*
(214) 238-9150

DATE
01/09/95

* * *

QUESTIONS FOR:
B. MOODLEY, VOCATIONAL COUNSELOR
RE: CAROLYN CLEVELAND SSN: 530-26-0461

Instructions: In answering the following questions, please base your answers on your education, experience, training, and Ms. Cleveland's medical and vocational history as obtained by you through interviews, vocational testing and medical records.

---

(1) Please provide your full name and address.

Bobby M. Moodley, Phd, LPC, CRC,

(2) Please provide your professional qualifications or attach a current resume.

Senior Counselor with Texas Rehabilitation Commission. Phd., Licensed Professional Counsel or (LPC), Certified Rehab. Counsel or (CRC)

(3) Did you interview Ms. Cleveland as an applicant for vocational services?

[✓] Yes.

[ ] No.

(4) When did you interview Ms. Cleveland?

June 7, 1994

(5) Did you assess her physical and mental ability in order to determine whether or not Ms. Cleveland would be able to successfully engage in gainful employment?

[✓] Yes.

[ ] No.

(6) What method(s) did you utilize in order to arrive at your decision?

(1) *Medical & Psychiatric & Vocational Records.*
(2) *Clinical Assessment.*
(3) *Clients self report.*

(7) In your opinion, is Ms. Cleveland a candidate for vocational training for future successful employment?

[ ] Yes.

[✓] No.

(8) If not, what conditions or symptoms interfere with Ms. Cleveland's ability to function properly in an employment setting?

Clients [sic] *has cognitive impairments and medical problems which may interfere with this clients ability to participate in competitive employment especially in employment in which she has done for over 30 yrs.*

2/10/95
Date

/s/ *B. Moodley*
B. MOODLEY
Vocational Counselor

Social Security
Notice of Reconsideration

From: Department of Health and Human Services
Social Security Administration

Date: APR 17 1995

Carolyn Cleveland
1806 Serenade
Richardson, TX 75081

Claim Number: 530-26-0461
Claim for
[X] Disability Insurance Benefits

* * *

Upon receipt of your request for reconsideration we had your claim independently reviewed by a physician and disability examiner in the State agency which works with us in making disability determinations. The evidence in your case has been thoroughly evaluated; this includes the medical evidence and the additional information received since the original decision. We find that the previous determination denying your claim was proper under the law. Attached to this notice is an explanation of the decision we made on your claim and how we arrived at it. The reverse of this notice identifies the legal requirements for your type of claim.

* * *

Noel D. Wall
Dallas Regional Commissioner

EXPLANATION OF DETERMINATION

Name of Claimant	SSN	Type of Claim
Carolyn Cleveland	530-26-0461	DI

* * *

In addition to the information used in your prior determination, the following medical information was used to decide this reconsideration claim:

Bob L. Gant, Ph.D., report of 1-9-95; Bob Moodley, P.D., report of 2-10-95; Mark A. Hardin, M.D., records 8-23-94 to 2-24-95.

We were unable to obtain additional reports; however, we had enough information to evaluate your condition. We have determined that your condition is not severe enough to keep you from working. We considered the medical and other information, your age, education, training and work experience in determining how your condition affects your ability to work. You said you were disabled because of residuals of a stroke. Reports show that you have some difficulty with memory. However, your current symptoms are not severe enough to be considered disabling under Social Security guidelines. Although a return to work done in the past is not possible, your condition does allow other less demanding work. This conclusion takes into consideration your age, education, and work history. If your condition gets worse and keeps you from working, write, call, or visit any Social Security office.

* * *

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

1. CLAIMANT
   Carolyn C Cleveland

3. SOC. SEC. CLAIM NUMBER
   530-26-0461

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because.

   I am unable to work due to my disability.

* * *

6. Check one of these blocks.

   [X] I have no additional evidence to submit at this time

* * *

[You should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 9.]

8. *Carolyn Cleveland*

* * *

Date 05/09/95

(REPRESENTATIVE'S SIGNATURE/NAME)
/s/ Carl Weisbrod

* * *

Date 05/09/95

* * *

MEDICAL SOURCE STATEMENT
About What the Claimant Can Still Do
Despite Impairment(s)

Name: *Carolyn Cleveland* SSN: *530-26-0461*

INSTRUCTIONS: Please complete the following assessment based on your clinical evaluation and test findings. You are not required to perform any special test of functional capacity to render your opinions on this form.

Please mark the activities the patient CAN perform on a sustained basis. "On a sustained basis" is defined as 40 hours per regular work week less a reasonable time daily for breaks.

A. Stand and/or walk:

(1) CONTINUOUSLY before alternating postures sitting or lying down:
(Circle one please)

<15 min 15 min 30 min 1 hr 2 hrs 3 hrs
4 hrs 5 hrs 6 hrs 7 hrs 8 hrs

(2) TOTAL during an 8-hour workday: (Circle one please)

<15 min 15 min *30 min* 1 hr 2 hrs 3 hrs
4 hrs 5 hrs 6 hrs 7 hrs 8 hrs

B. Sit, (i.e., at a table or bench without opportunity to recline, elevate the legs, etc.)

(1) CONTINUOUSLY before alternating postures standing or lying down: (Circle one please)

<15 min *15 min* 30 min 1 hr 2 hrs 3 hrs
4 hrs 5 hrs 6 hrs 7 hrs 8 hrs

(2) TOTAL during an 8-hour workday: (Circle one please)

<15 min 15 min 30 min *1 hr* 2 hrs 3 hrs
4 hrs 5 hrs 6 hrs *7 hrs* 8 hrs

C. Lying down (i.e. resting in supine posture)
Can it reasonably be expected that this individual will require rest lying down during an 8 hour workday for pain management and/or fatigue?

[ ] Yes, for pain management

[X] Yes, due to fatigue

[ ] No

D. Lift (including upward pulling) and/or carry:

	Constantly (≥2/3 of 8 hrs)	Frequently (1/3-2/3 of 8 hrs)	Occasionally (<1/3 of 8 hrs)	None (no sustained/ 8 hrs)
Weight in Pounds				
Up - 5 lbs.	____	____	X	____
6 - 10 lbs.	____	____	X	____
11 - 20 lbs.	____	____	____	X
21 - 50 lbs.	____	____	____	X
51 - 100 lbs.	____	____	____	X

F. Repetitive use of arm: (Complete each subsection).

	Constantly (≥2/3 of 8 hrs)	Frequently (1/3-2/3 of 8 hrs)	Occasionally (<1/3 of 8 hrs)	None (no sustained/ 8 hrs)
Reaching with RIGHT arm.	____	____	X	____
Reaching with LEFT arm.	____	____	____	X

Grasping with RIGHT hand.	____	____	X	____
Grasping with LEFT hand.	____	____	____	X
Fingering with RIGHT hand.	____	____	X	____
Fingering with LEFT hand.	____	____	____	X

G. Period of Restriction:

Has the patient's condition existed and persisted with the restrictions as outlined in this Medical Source Statement at least since *January, 1994?*

[X] Yes [ ] No

If not, state the first date the patient's condition existed and persisted with such restrictions:

_____, 19__

H. Diagnoses: This assessment is premised upon my diagnoses of:

CVA L HEMIPARESIS

CERTIFICATION

By my signature appended hereto, I attest that I have answered truthfully and accurately to the best of my ability, each of the questions prestated in this Medical Source Statement.

Dated *7/6/95*, 199__.

/s/ *Leslie D. Porter, MD*
Leslie D. Porter, MD
Medical Director
Baylor Institute for Rehabilitation

_____

NOTE TO PROCESSING CENTER
FURTHER ACTION NECESSARY

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Social Security Administration
OFFICE OF HEARINGS AND APPEALS

DECISION

CLAIM FOR

IN THE CASE OF

Carolyn C. Cleveland
(Claimant)

_____
(Wage Earner)

Period of Disability, Disability Insurance Benefits, and Supplemental Security Income

_____

530-26-0461
(Social Security Number)

This case is before the undersigned on a timely request for a hearing filed by the claimant, who is dissatisfied with the determinations denying her applications for a period of disability, disability insurance benefits, and supplemental security income benefits.

Based on the evidence of record, the undersigned finds that the claimant has the limitations as identified in the attached document incorporated herein by reference. Given these findings of fact, the undersigned has concluded that the claimant became disabled on January 7, 1994, and continues to be disabled through the date of this decision.

IT IS THE DECISION OF THE ADMINISTRATIVE LAW JUDGE that, based on the application for disability insurance benefits dated January 28, 1994 (with protective filing date of January 11, 1994), the claimant is entitled to a period of disability commencing January 7, 1994 and to disability insurance benefits, pursuant to the Social Security Act and the regulations promulgated thereto.

IT IS THE FURTHER DECISION OF THE UNDERSIGNED that the claimant has been disabled at all times from the current supplemental security income filing date of January 28, 1994 (with protective filing date of January 11, 1994), through the date of this decision.

The claimant is eligible for supplemental security income benefits *if and to the extent* the nondisability requirements therefor have been met. This case is remanded to the appropriate unit of the Social Security Administration for investigation of the nondisability factors. Once that investigation has been completed, the Administration shall advise the claimant whether she is eligible for supplemental security income payments and, if so, the amount and the month(s) for which benefits will be paid.

/s/ *Harold G. Adams*
HAROLD G. ADAMS
Administrative Law Judge

29 SEP 1995
Date

DECISIONAL FINDINGS OF FACT

Name: Carolyn C Cleveland SSN: 530-26-0461

Claim Type: SSDC

Primary Disabling Impairment (Diagnosis):
Status Post
Cerebrovascular Accident

Meets Listing:
Yes [ ] No [X] Listing Number [ ]

Equals Listing:
Yes [ ] No [X] Listing Number [ ]

RESTRICTIONS (Place an "X" before each applicable restriction)

Physical

[X] Walking	[X] Reaching
[X] Standing	[X] Carrying
[X] Sitting	[X] Handling
[X] Lifting	[ ] Seeing
[X] Pushing	[X] Hearing
[X] Pulling	[X] Speaking
[ ] Other: _____	

Mental

[X] Understand, carry out, & remember simple instructions

[X] Use of Judgement

[ ] Respond appropriately to supervision, co-workers, and usual work situations

[X] Deal with changes in routine work settings

[ ] Other: _____

* * *

CURRENT PHYSICAL RESIDUAL FUNCTIONAL CAPACITY (RFC)

JOB CLASSIFICATION	Complete Range	Wide Range	Limited Range
Very Heavy	____	____	____
Heavy	____	____	____
Medium	____	____	____
Light	____	X	____
Sedentary	____	____	____
Below Sedentary	____	____	____

MEDICAL-VOCATIONAL RULES

a. Age: 58 DOB: August 17, 1935

[ ] Younger
[ ] Closely Approaching Advanced Age
[X] Advanced Age

b. Education

[ ] Illiterate
[ ] Marginal
[ ] Limited
[X] High School & Above
[ ] Inability to communicate in English

c. Occupation

[ ] Unskilled
[X] Semi-Skilled

[ ] Skilled
[X] Non-transferable
[ ] Transferable

Combination of Impairments/
Non-exertional factors

Rule 202.06 Framework Yes [ ] No [X]

Special Medical Re-examination Diary Instructions (If Applicable)

Drug Addiction/Alcoholism Sanctions
Yes [ ] No [X]

Capability Development Needed
Yes [ ] No [X]

Comments:

/s/ Harold G. Adams
HAROLD G. ADAMS
Administrative Law Judge

OHA PSYCHIATRIC REVIEW TECHNIQUE FORM

NAME: Carolyn C Cleveland SSN: 530-26-0461

Assessment is for:
Other: January 7, 1994 to present

Administrative Law Judge's Signature — Date
/s/ *Harold G. Adams* — 29 SEP 1995

I. MEDICAL SUMMARY

A. Medical Disposition(s):
RFC Assessment Necessary (i.e., a severe impairment is present which does not meet or equal a listed impairment)

B. Based Upon Category(ies): 12.02, 12.04

II. Reviewer's Notes (Does not apply to OHA)

III. DOCUMENTATION OF FACTORS THAT EVIDENCE THE DISORDER (Evaluation of the existence of a sign or symptom CLUSTER or SYNDROME for the Listed Disorder.)

PRESENT	ABSENT			
[x]	[ ]	A.	12.02	Organic Mental Disorders
[ ]	[x]	B.	12.03	Schizophrenic, Paranoid and other Psychotic Disorders
[x]	[ ]	C.	12.04	Affective Disorders
[ ]	[x]	D.	12.05	Mental Retardation and Autism
[ ]	[x]	E.	12.06	Anxiety Related Disorders
[ ]	[x]	F.	12.07	Somatoform Disorders
[ ]	[x]	G.	12.08	Personality Disorders
[ ]	[x]	H.	12.09	Substance Addiction Disorders

A. **12.02 Organic Mental Disorders** – Psychological or behavioral abnormalities associated with a dysfunction of the brain . . . as evidenced by at least one of the following:

PRESENT-ABSENT-INSUFFICIENT EVIDENCE

1. [ ] [x] [ ] Disorientation to time and place
2. [x] [ ] [ ] Memory Impairment
3. [ ] [ ] [ ] Perceptual or thinking disturbances
4. [ ] [ ] [ ] Change in personality
5. [ ] [ ] [ ] Disturbance in mood
6. [x] [ ] [ ] Emotional Mobility and impairment in impulse control
7. [ ] [ ] [ ] Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.
8. [ ] [ ] [ ] Other

C. **12.04 Affective Disorders** – Disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by at least one of the following:

PRESENT-ABSENT-INSUFFICIENT EVIDENCE

1. [x] [ ] [ ] Depressive syndrome characterized by at least four of the following:

   a. [ ] Anhedonia or pervasive loss of interest in almost all activites, or

b. [ ] Appetite disturbance with change in weight, or

c. [ ] Sleep disturbance, or

d. [x] Psychomotor agitation or retardation, or

e. [x] Decreased energy, or

f. [ ] Feelings of guilt or worthlessness, or

g. [x] Difficulty concentrating or thinking, or

h. [x] Thoughts of suicide, or

i. [ ] Hallucinations, delusions or paranoid thinking

2.[ ] [ ] [ ] Manic syndrome characterized by at least three of the following:

a. [ ] Hyperactivity, or

b. [ ] Pressures of speech, or

c. [ ] Flight of ideas, or

d. [ ] Inflated self-esteem, or

e. [ ] Decreased need for sleep, or

f. [ ] Easy distractibility, or

g. [ ] Involvement in activities that have a high probability of painful consequences which are not recognized, or

h. [ ] Hallucinations, delusions or paranoid thinking

3. [ ] [ ] [ ] Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently

characterized by either or both syndromes)

4. [x] [ ] [ ] Other: Organic Mood Disorder

IV. RATING OF IMPAIRMENT SEVERITY

A. "B" CRITERIA OF THE LISTINGS

THE FOLLOWING FUNCTIONAL LIMITATIONS (WHICH APPLY TO PARAGRAPH B OF LISTINGS 12.02-12.04 AND 12.06-12.08 AND PARAGRAPH D OF 12.05) EXIST AS A RESULT OF THE INDIVIDUAL'S MENTAL DISORDER(S).

NOTE: ITEMS 3 AND 4 BELOW ARE MORE THAN MEASURES OF FREQUENCY. DURATION AND EFFECTS OF THE DEFICIENCIES (ITEM 3) OR EPISODES (ITEM 4) ARE DISCUSSED IN THE DECISION.

Listing(s) under which the items below are being rated: 12.02, 12.04

FUNCTIONAL LIMITATION AND DEGREE OF LIMITATION

1. Restrictions of Activities of Daily Living:

None[ ] Slight[ ] Moderate[x]
Marked*[ ] Extreme[ ] Insuff Evid[ ]

2. Difficulties in Maintaining Social Functioning:

None[ ] Slight[ ] Moderate[x]
Marked*[ ] Extreme[ ] Insuff Evid[ ]

3. Deficiencies of Concentration, Persistence or Pace Resulting in Failure to Complete Tasks in a Timely Manner (in work settings or elsewhere):

Never[ ] Seldom[ ] Often[ ]
Frequent*[X] Constant[ ] Insuff Evid[ ]

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4. Episodes of Deterioration or Decompensation in Work or Work-Like Settings Which Cause the individual to Withdraw from that Situation to Experience Exacerbation of Signs and Symptoms (which may Include Deterioration of Adaptive Behaviors):

Never[ ] Once/Twice[x] Repeated*(3+)[ ]
Continual[ ] Insuff. Evid[ ]

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*Degree of limitation that satisfies the Listings: Extreme, Constant and Continual also satisfy that requirement.

B. Summary of Functional Limitation Rating for "B" Criteria

NO. OF FUNCTIONAL LIMITATIONS MANIFESTED AT THE LISTING LEVEL: [1] (The number must be at least 2 to satisfy the requirements of paragraph B in Listings 12.02, 12.03, 12.04 and 12.06 and paragraph D in 12.05; and at least 3 to satisfy the requirements in paragraph B in Listings 12.07 and 12.08.)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CAROLYN C. CLEVELAND	)	
v.	)	
POLICY MANAGEMENT SYSTEMS CORPORATION, GENERAL INFORMATION SERVICES, A DIVISION OF POLICY MANAGEMENT SYSTEMS CORPORATION and CYBERTEK CORPORATION	)	CIVIL ACTION NO. 3:95-CV-2140-H

AFFIDAVIT OF CAROLYN C. CLEVELAND

BEFORE ME, the undersigned authority, on this day personally appeared Carolyn C. Cleveland, who is known to me and, who after being duly sworn, deposed as follows:

"My name is Carolyn C. Cleveland. I am over the age of 21 years of age, am of sound mind and am in all ways competent to make this oath. All of the matters expressed herein are true and correct and are of my personal knowledge. I am the Plaintiff in the above-styled case. I was employed by the Defendant, Policy Management Systems Corporation ("PMSC").

I began my employment with PMSC in approximately August 1993. I was hired by Anthony Clark, a manager, with the understanding that if the company received the pending contract from the post office, I would supervise the night shift. In the beginning, I was assisting with insurance

investigations which the company had fallen behind on. Mr. Clark had me assisting the reporters and also assisting Judy Threadgill, an investigator, with her regular reports. When the company acquired the contract, Mr. Clark told me he would prefer it if I continued assisting the reporters. Clark told me it would take a long time to find someone with my qualifications to replace me. Mr. Clark told me he was pleased with my work and complimented me on my attitude.

In approximately December 1993, I began receiving my own reports. I was however placed in a cubicle with three noisy co-workers which made it difficult to concentrate. I complained to my supervisor Debra Levine, but she said there was nothing she could do. On January 7, 1994, I complained again, and Levine said I could move to the credit machine area. I moved by belongings and that day I had a stroke while on the job. The following Monday, one of my daughters, called Levine to tell her I had a stroke and would not be coming to work. It was my understanding from my daughter that Levine said I should come into work. During the time I was off as a result of the stroke, Levine and Clark kept calling me pressuring me back to work.

Dr. Herzog was my treating physician for my stroke. The stroke effected [sic] my ability to speak and to concentrate. For [sic] period of time after the stroke, I could not talk. Also, I could not read or dial a phone, and I had trouble understanding most of what was said to me. I was very frightened and felt helpless. The stroke also effected [sic] my memory. I can remember things sometimes and other times I cannot

remember things. As I understand it from my doctors, this condition is called aphasia and it is essentially a problem with memory in that sometimes I can remember names or places and other times I cannot remember. I went through speech rehabilitation after my stroke and by April 1994, I was able to speak fairly well. I worked extremely hard in rehab to recover by following my doctor's instruction. (Please also see the Affidavit of Dr. Herzog attached to Plaintiff's Amended Response to Defendant's Motion for Partial Summary Judgment).

In approximately January 1994, after I had my stroke, one of my daughters, filed a claim for social security disability benefits on my behalf. Although I apparently signed the social security disability application which was initially filed, my daughter initiated the filing of the claim and filled out the paperwork. I do not specifically recall signing the social security application in January 1994. In approximately April 1994, I was released to return to work. My physical condition had improved between January 1994 and April 1994. During the time between my return to work and my termination, I did not pursue social security benefits. Shortly after I returned to work, I contacted the Social Security Administration and informed them that I was returning to work and did not need social security disability benefits. I contacted the Social Security Administration because I received some paperwork from them, and I wanted them to know I was working and would not need benefits. I returned to work at PMSC in April 1994 on a part-time basis. I worked part-time for about two weeks and then started working full time. I was fearful about returning to work, but

Clark and Levine said they would help me and would provide another job if necessary.

As I was not fully recovered from the stroke, I was having a difficult time with the increased workload. I had started getting regular reports in December 1993, but then I had the stroke on January 7, 1994. Prior to my stroke I was given very little training on the reports. When I returned to work after the stroke, I was given no additional training or help, even though I asked for the training I had not received. For instance, I asked for computer training, but was denied this by Debra Levine so I had to keep doing my reports on a typewriter.I also tried taking work home to try and catch up, but Debra Levine forbid [sic] me to do this. In dealing with me at work, I observed that Debra Levine acted as if she did not believe that I was having problems such as aphasia. In response to Levine's treatment of me, I informed Levine that Dr. Moodly, with the Texas Rehabilitation Commission, offered to send someone through the Texas Rehabilitation Commission to assist me free of charge, and offered to talk with my employer and explain aphasia. Debra Levine's response to my statements regarding Dr. Moodly's offers of assistance, was that I could not have help and that she would not talk to Dr. Moodly.

Also, Levine and my co-workers would make cruel remarks, mimic me and laughed at my speech problems. Negative remarks were made about my work by Levine. In an effort to do a good job, I kept asking Levine for help and explanations, but she would just put me off. On several occasions, I asked for a transfer to a position which would have been easier on me,

but was denied by Debra Levine, my supervisor. I was treated like trash by Levine and my co-workers in that they mocked me and belittled my medical condition by sarcastically mimicking my speech impediment which I developed after the stroke. On June 3, 1994 Levine gave me a written warning alleging poor performance.

After the written warning I doubled my efforts to produce quality work. The day or two before my termination, I had been encouraged because I was finally getting some assistance from Jean Holbert, an investigator, with using the computer. Also, Sharon Russell, an inspector, gave me training to interpret the credit reports. Russell also helped me with the criminal reports. I was feeling good because for so long I had been trying to get training and assistance and each time I would go to Debra Levine she would not help. Levine would claim to be too busy or would say she would help me later, but she did not help. I felt positive about my job performance, and I was crushed emotionally when I was terminated. I felt like I had climbed a high mountain and was kicked off just as I was getting near the top. (For additional details, see also the Affidavit of Dr. Herzog attached to Plaintiff's Amended Response to Defendant's Motion for Partial Summary Judgment).

On or about July 14, 1994, I was told by Peter Moore, the Regional Vice President, and Debra Levine that I was terminated. I was told I was being terminated because of poor job performance.

In response to being told of my termination, I begged Peter Moore to let me keep my job or move to another job. Moore told me that his

father had a stroke and has not been able to do anything since then and that I would not be able to do anything either. Also, Mr. Moore told me that I would not be able to afford to continue my insurance.

During my initial termination meeting, Moore agreed to review my work. The next day, Moore again told me I was terminated.

As a result of my termination in July 1994, I was devastated emotionally. I became depressed as a result of the humiliating way I was treated and terminated by PMSC. My aphasia became worse after my termination. After my termination, my physical condition became worse and I began to feel like I could not do anything. I was fatigued and depressed. This was the reason I filed for social security benefits after my termination. I began seeing a psychologist, Dr. Gant, in approximately December 1994 because of my depression and worsening condition. I was granted social security benefits in approximately November/December 1995.

FURTHER AFFIANT SAYETH NOT.

/s/ *Carolyn C. Cleveland*
Carolyn C. Cleveland

SWORN TO AND SUBSCRIBED before me this *6th* day of *August*, 1996.

/s/ *Daion Christenson*
Notary Public in and
for the State of Texas
[SEAL] DAION M. CHRISTENSON
MY COMMISSION EXPIRES
JULY 3, 2000

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CAROLYN C. CLEVELAND	)	
v.	)	
POLICY MANAGEMENT SYSTEMS CORPORATION, GENERAL INFORMATION SERVICES, A DIVISION OF POLICY MANAGEMENT SYSTEMS CORPORATION and CYBERTEK CORPORATION	)	CIVIL ACTION NO. 3:95-CV-2140-H

AFFIDAVIT OF STEVEN P. HERZOG, M.D.

BEFORE ME, the undersigned authority, on this day personally appeared STEVEN P. HERZOG, M.D., who is known to me and, who after being duly sworn, deposed as follows:

"My name is Steven P. Herzog, M.D. I am over the age of 21 years of age, am of sound mind and am in all ways competent to make this oath. All of the matters expressed herein are true and correct and are of my personal knowledge.

I am a medical doctor licensed to practice medicine in the State of Texas. I am a Board Certified Neurologist. I am employed with the Dallas Neurological Clinic. A true and correct copy of my curriculum vitae is attached hereto.

From approximately January 11, 1994 to the present I have been Carolyn C. Cleveland's treating physician for the stroke she suffered on or about January 7, 1994. Specifically, in January

1994, I diagnosed Ms. Cleveland has having a post cerebral vascular accident (stroke) in the left cerebrum with resultant damage to the language center. The stroke left Ms. Cleveland with an aphasia. An aphasia is a disorder of input and output of language which affects one's reading ability, calculation ability, understanding and processing of all language function.

From January 1994 to April 1994, Ms. Cleveland showed significant progress in her recovery from her stroke. (It sometimes takes 6-12 months to recover fully from a stroke.) I released Ms. Cleveland to return to work in April 1994 on a part-time basis. At that time, I felt that Ms. Cleveland's prognosis was positive for continued improvement, and I felt that she would eventually reach a near 100% recovery.

After approximately two weeks on the job, Ms. Cleveland's employer requested that I release her to return to work full-time. I continued to treat Ms. Cleveland and monitor her progress after she returned to work. Ms. Cleveland, however, encountered difficulties in her performing her job including a lack of training, memory problems, time pressures and communication problems.

Prior to Ms. Cleveland's termination on July 15, 1994, the problems related to Ms. Cleveland's stroke were significantly decreasing, and she was able to communicate more easily. Ms. Cleveland's spelling had improved, even with difficult words. Ms. Cleveland was experiencing few problems with aphasia, but still needed some additional time to recover fully from her stroke. Prior to Ms. Cleveland's termination, I

had anticipated that Ms. Cleveland would ultimately reach a near 100% recovery.

After Ms. Cleveland was terminated she became depressed and her aphasia became worse. It was not until Ms. Cleveland was terminated, that she suffered this set back in her recovery.

In December 1994, I became concerned that Ms. Cleveland was having both emotional and neuropsychological problems secondary to her stroke and the depression over her termination. I referred Ms. Cleveland to Dr. Gant for a psychological analysis and treatment.

It is my opinion and belief based on a reasonable degree of medical probability and a review of Ms. Cleveland's symptoms and situation that Ms. Cleveland became depressed as a result of her termination and that her depression over her termination caused her aphasia to worsen. It is my opinion that had Ms. Cleveland been given training, time and assistance on the job, instead of being terminated, she would have continued to recover from the stroke. With time, understanding and therapy Ms. Cleveland has slowly begun to recover from the post-termination relapse of her aphasia and depression. Ms. Cleveland's current prognosis is good.

The statements in this affidavit are based on my review of Ms. Cleveland's symptoms, her situation and the history obtained from her, as well as a reasonable degree of medical probability.

FURTHER AFFIANT SAYETH NOT.

/s/ *Steven P. Herzog*
Steven P. Herzog, M.D.

SWORN TO AND SUBSCRIBED before me this *17th* day of *July*, 1996.

/s/ *Marie Yvette Boothe*
Notary Public in and
for the State of
Texas
[SEAL] MARIE YETTE BOOTHE
MY COMMISSION EXPIRES
AUGUST 19, 1997

CURRICULUM VITAE

STEVEN P. HERZOG, M. D.

Office	The Dallas Neurological Clinic 712 N. Washington, Suite 100 Dallas, Texas 75246 214-827-3610
Home Address	1228 N. Windomere Dallas, Texas 75208 214-943-6313
Date of Birth	April 17, 1959
Undergraduate Education 1977-1981	Arizona State University, Tempe Arizona Bachelors Degree In Biology, Cum Laude.

Postgraduate Education 1981-1985	University of Arizona College of Medicine Graduating Class of 1985, Degree-Medical Doctor.
Professional Education 1985-1986	General Medicine Internship, Tulane University Affiliated Charity Hospital, New Orleans, Louisiana.
1986-1988	Resident in Neurology, University of Texas Southwestern Medical Center at Dallas, Parkland Memorial Hospital.
1988-1989	Chief Resident in Neurology, University of Texas Southwestern Medical Center at Dallas, Parkland Memorial Hospital.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CAROLYN C. CLEVELAND	)	
	)	
v.	)	
POLICY MANAGEMENT	)	
SYSTEMS	)	CIVIL ACTION NO.
CORPORATION, GENERAL	)	3:95-CV-2140-H
INFORMATION SERVICES, A	)	
DIVISION OF POLICY	)	
MANAGEMENT SYSTEMS	)	
CORPORATION and	)	
CYBERTEK CORPORATION	)	

AFFIDAVIT OF SHERI SHORT

BEFORE ME, the undersigned authority, on this day personally appeared Sheri Short, who is known to me and, who after being duly sworn, deposed as follows:

"My name is Sheri Short. I am over the age of 21 years of age, am of sound mind and am in all ways competent to make this oath. All of the matters expressed herein are true and correct and are of my personal knowledge. I am the daughter of Carolyn Cleveland, the Plaintiff in the above-styled case. I am presently employed by Esmore, a private corrections corporation. I was previously employed by Tarrant County Adult Probation Department for approximately 14 years.

On or about Saturday, January 8, 1994, I took my mother, Carolyn Cleveland, to the hospital. My mother was admitted to the hospital for treatment for a stroke she had suffered.

After my mother's stroke, I assisted her with her personal business such as the bills and insurance. Shortly after the stroke, I observed problems my mother was experiencing with communication, comprehension and memory. I was concerned about my mother and worried about what would happen if she did not recover. My response to a crisis situation is to prepare for the worst case scenario, so I obtained an application for food stamps, information from HUD, and an application for social security disability benefits from the Social Security Administration. While working for the government for so many years, I observed that it often took a long time to process paperwork; therefore, I requested these applications quickly in the event my mother would need benefits. I filled in information on the social security disability application. I then gave the application to my mother to sign, and I observed her sign the application. The application was dated 1-21-94. I then filed the claim for social security disability benefits for my mother. I took my mother to therapy, and I observed that she was recovering quickly from the stroke. I observed my mother's speech and ability to communicate improve, as well as her memory and comprehension.

After my mother was terminated in July 1994, I observed the following behavior in my mother: she acted more depressed, she appeared fatigued, she would often cry when I spoke to her. I have spoken to my mother approximately every day since she had the stroke and have personally observed her physical and emotional condition. I observed the physical and emotional changes she went through after the stroke, after her return to work and after her

termination. My mother appeared emotionally devastated after the termination.

FURTHER AFFIANT SAYETH NOT.

/s/ *Sheri Short*
Sheri Short

SWORN TO AND SUBSCRIBED before me this *8th* day of *August*, 1996.

/s/ *Daion Christenson*
Notary Public in and
for the State of
Texas

[SEAL] DAION M. CHRISTENSON
MY COMMISSION EXPIRES
JULY 3, 2000
